

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

## 1. PLACE OF DEATH:

County Anne Arundel CountyCity or town Crownsville, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:

Crownsville State HospitalHow long in hospital or institution? 8 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County -----City or town Baltimore City  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1605 McCulloch Street  
(If rural, give LOCATION)2(a) If veteran, name war ✓

## 3. (a) FULL NAME

AGARD - MADELINE

## 3. (b) Social Security Number

unknown

## 4. Sex

female

## 5. Color or race

black

## 6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Edward Agard, 1543 Division  
St., Balto., Md.7. Birth date of  
deceased (mo., day, yr.) 18916. (c) If alive, give age unk. years

## 8. AGE:

Years

Months

Days

If less than one day

55unknown----- hrs.----- min.9. Birthplace unknown  
(Town, county, and state)10. Usual occupation unknown

## 11. Industry or business

## FATHER

12. Name unknown13. Birthplace unknown

## MOTHER

14. Maiden name unknown15. Birthplace unknown16. Informant Hospital RecordsAddress Crownsville, Maryland17. Burial Date thereof July 5, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. AuburnLocation Baltimore, Md.18. Funeral director Mrs. George W. HallandAddress 1631 Rural Hill Ave.19. (Date rec'd by registrar) 19

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 19 46, at 7:00 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 22 19 46 to June 30 19 46  
and that I last saw him er alive on June 30 19 46

## Immediate cause of death

General ArteriosclerosisDURATION  
Known to  
us since  
6/22/46

Due to

Due to

Other conditions Psychosis with Other Somatic Known to  
Diseases - Diabetes Mellitus us since  
(Include pregnancy within 8 months of death) 6/22/46

## Major findings of operations

Date of op. -----

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----Where did injury occur? -----  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) -----Means of injury ----- Injured at work? -----23. SIGNATURE Dr. J. H. Hinkley  
M. D. or otherAddress Crownsville, Maryland Date signed 6/30/46

RECEIVED

JUL 11 1946

BUREAU V.E.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

## CERTIFICATE OF DEATH

\*0560128  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County... Anne Arundel County  
City or town... Crownsville, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 years, 20 days  
Hospital, institution, or street address where death occurred:  
Crownsville State Hospital  
How long in hospital or institution? 7 years, 20 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... Maryland  
City or town... Baltimore City  
(If outside city or town limits, write RURAL and give nearest town)  
Street No... unknown  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

BARNES - DAISY

### 3. (b) Social Security Number

4. Sex female 5. Color or race black 6. (a) Single, married, widowed, or divorced single (?)

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1912 6. (c) If alive, give age years

8. AGE: Years 34 Months unknown Days It less than one day

9. Birthplace unknown (Town, county, and state)

10. Usual occupation unknown

11. Industry or business

FATHER 12. Name unknown 13. Birthplace unknown

MOTHER 14. Maiden name unknown 15. Birthplace unknown

16. Informant Hospital Records Address Crownsville, Maryland

17. Buried Date thereof June 10, 1946 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Peter's Location Baltimore, Maryland

18. Funeral director George G. Kelson Address 1303 Presstman St., Baltimore, Md.

19. June 7, 1946 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1946 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12, 1939 to June 2, 1946 and that I last saw her alive on June 2, 1946.

Immediate cause of death Pulmonary Tuberculosis (Cold abscess) DURATION Known to us since 4/9/44

Due to

Other conditions Schizophrenia - Catatonic Known to us since 5/12/39 Type (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work?

23. SIGNATURE Address Crownsville, Maryland Date signed 6/2/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
JUN 8 1946  
BUREAU 13

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30d

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

## 1. PLACE OF DEATH:

County... Anne Arundel County

City or town... Crownsville, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 3 mos. 10 days

Hospital, institution, or street address where death occurred:  
Crownsville State Hospital

How long in hospital or institution? 1 yrs, 3 mos, 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Frederick

City or town... Frederick  
(If outside city or town limits, write RURAL and give nearest town)Street No... 113 East Fifth Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

BARNES - SAMUEL HARRY

## 3. (b) Social Security Number

unknown

4. Sex... male 5. Color or race... black 6.(a) Single, married, widowed, or divorced... single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1905

8. AGE: Years 41 Months 2 Days 24 If less than one day  
--- hrs. --- min.9. Birthplace... Maryland  
(Town, county, and state)

10. Usual occupation... Laborer

11. Industry or business... unknown

12. Name... Jerry Barnes

13. Birthplace... Maryland

14. Maiden name... Elizabeth ?

15. Birthplace... Maryland

16. Informant... Hospital Records

Address... Crownsville, Maryland

17. Buried Date thereof June 21, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Fairview Cemetery

Location... Frederick, Maryland

18. Funeral director... M.R. Etchison &amp; Son

Address... Frederick, Maryland

19. June 19 1946 2-7 Joyce Local  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1946 at 12:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9 1945 to June 19 1946 and that I last saw him alive on June 19 1946

Immediate cause of death... General Paresis

DURATION Known to us since 3/9/45

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address... Crownsville, Maryland Date signed... 6/19/46

MARGIN RESERVED FOR BINDING

VS A15 9-25-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 21 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

## CERTIFICATE OF DEATH

Reg. Dist. No. 23

## 1. PLACE OF DEATH:

County... St. Louis Co.City or town... Shipley  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... A.D. Co.City or town... Shipley  
(If outside city or town limits, write RURAL and give nearest town)Street No. Main + Anderson Rd  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Louis Bauer

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Mary F.

6. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.)

March 2, 1852

8. AGE:

Years

Months

Days

If less than one day

94

...hrs. ...min.

9. Birthplace

Maryland  
(Town, county, and state)

10. Usual occupation

Helper (Retired)

11. Industry or business

FATHER

12. Name

John Bauer

13. Birthplace

Germany

MOTHER

14. Maiden name

Katherine Reulner

15. Birthplace

Germany

16. Informant

Mr. Earl W. Bauer

Address

Main + Anderson Rd - Shipley

17.

(Burial, cremation, or removal. Which?)

Date thereof

6/29/46  
(month) (day) (year)

Cemetery or crematory

Bedard Hill

Location

Amagokis Blvd

18. Funeral director

John F. Henning Inc

Address

19.

(Date read by registrar)

19.

46A. W. Hedrick

Registrar

23. SIGNATURE

Frederick Bentler

Address

Thurs 18 - 46 - 125 Kenton Bldg  
Date signed

## MEDICAL CERTIFICATION

20. DATE OF DEATH... June 27<sup>th</sup> 19... 46 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... 42 to... 1946

and that I last saw him alive on

Thurs 19... 46

Immediate cause of death

Quarantine arterioSclerosis& cerebralDegeneration

Ducts

Refusal to eat

Ducts

Large decorticated U.C. cells

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frederick Bentler

Address

Thurs 18 - 46 - 125 Kenton Bldg  
Date signed

Dr. Butler

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

## CERTIFICATE OF DEATH

05604

Reg. Dist. No. 21

### 1. PLACE OF DEATH:

County Anne Arundel  
City or town Annapolis Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Emergency Hospital

How long in hospital or institution? 2

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County Anne Arundel  
City or town SEVERNA PARK  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3.(a) FULL NAME

Elizabeth Baby Girl Beck

### 3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife \_\_\_\_\_

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) June 12 1946

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Annapolis Md.  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Earl W. Beck

13. Birthplace Crisfield Md.

14. Maiden name Margie E. Stitt

15. Birthplace Baltimore Md.

16. Informant Earl W. Beck

Address Severna Park, Jr & Co Md

17. Burial Date thereof June 33 1946  
(Burial, cremation, or removal. Whichever) (month) (day) (year)

Cemetery or crematory At Annapolis Md

Location Annapolis Md.

18. Funeral director John W. Taylor & Son

Address Annapolis Md.

19. June 3 1946  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1946 at 4 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death \_\_\_\_\_

Born at 5 months  
lived 1 hour

Due to Premature 4 months

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE George C Basil M. D. or other \_\_\_\_\_

Address Annapolis Md Date signed 6-1-46

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUN 4 1946

BUREAU V S.

The clerk in the record room of the  
Emergency Hospital called to say the Mother of  
this child is quite upset that the name  
Elizabeth was left off this certificate. Will  
you please see that the Name  
ELIZABETH BECK is put on this.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 112

## CERTIFICATE OF DEATH

15605

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Dead upon arrival  
 Hospital, institution, or street address where death occurred:  
Emergency Hospital  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Ind. County DeWitt  
 City or town Upper Marlboro  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Michael Reeves Blanford

## 3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.

7. Birth date of

deceased (mo., day, yr.)

10/1/34

8. AGE:

Years

Months

Days

If less than one day

11810

hrs.

min.

9. Birthplace

Pittsburg, Pennsylvania  
(Town, county and state)

10. Usual occupation

11. Industry or business

12. Name

Reeves Blanford

13. Birthplace

Washington State

14. Maiden name

Regina Mondoff

15. Birthplace

Emmitsburg, Ind.

16. Informant

Mr. Reeves Blanford

Address

Upper Marlboro

17.

(Burial, cremation, or removal. Which?)

Date thereof

6-26-46  
(month) (day) (year)

Cemetery or crematory

Mr. Carmel

Location

Upper Marlboro, Ind.

18. Funeral director

Pittsburg Bros.

Address

Upper Marlboro, Ind.

19.

Date rec'd by registrar

1946

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 231946

at

2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

Acute dilatation of the heart

DURATION

Two minutes

Due to

Bronchial asthma9 years

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Kustave H. Paulsen M.D.

M. D. or other

Address

Upper Marlboro Ind.

Date signed

6/22/46

RECEIVED  
JUN 25 1946  
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 302

## CERTIFICATE OF DEATH

05606

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co.City or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)Street No. Carroll Hall  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Edwin Russell Boyd

## 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Evangeline Boyd

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16th 18918. AGE: Years 55 Months - Days 8 If less than one day  
hrs. min.9. Birthplace Maine  
(Town, county, and state)10. Usual occupation Chief at Carroll Hall

## 11. Industry or business

12. Name unknown13. Birthplace unknown14. Maiden name unknown15. Birthplace unknown16. Informant Mrs. C. R. BoydAddress Annapolis, Maryland17. Burial Date thereof June 25, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Chick, West Virginia18. Funeral director John M. Taylor & SonAddress Annapolis, Maryland19. June 24 19 46  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 24 June 19 46, at 2:35 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 June 19 46, to 24 June 19 46, and that I last saw him alive on 24 June 19 46Immediate cause of death Cardiac decompensation  
and failure

## DURATION

Due to arterio-sclerotic insufficiencyDue to hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations No operation doneAutopsy results No autopsy done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Donald H. Hester, M.D.Address 53 Cornhill Date signed 24 June 46

W.

RECEIVED

JUN 26 1946

BUREAU V.S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 056021

### 1. PLACE OF DEATH:

County Anne Arundel  
City or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Emergency Hospital  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County 44 Co.  
City or town Eastport  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Tyler Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war World War I

### 3. (a) FULL NAME

William Henry Boyd

### 3. (b) Social Security Number

219-12-5936

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Margaret R. Boyd  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) June 17, 1895  
8. AGE: Years 51 Months 11 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Pennsylvania  
(Town, county, and state)  
10. Usual occupation Machinist - USN  
11. Industry or business

12. Name unknown  
13. Birthplace unknown  
14. Maiden name unknown  
15. Birthplace unknown

16. Informant Mrs. W. H. Boyd  
Address Tyler Ave. Eastport

17. Burial Date thereof June 5<sup>th</sup> '46  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory M. E. Church  
Location Filghamoni Isl. - Md.

18. Funeral director J. Fred Moore  
Address Filghamoni Isl. - Md.

19. June 4 19 46  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 19 46 at 12 PM  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 2 19 46 to June 1 19 46  
and that I last saw him alive on June 1 19 46  
Immediate cause of death

Coronary embolism sudden

Due to Coronary sclerosis 2 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE John M. Caffey M.D.  
Address Annapolis, Md. Date signed 6/3/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 5 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

05608

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County 2 aCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

Emergency HospitalHow long in hospital or institution? 12 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a aCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)Street No. 24 Monroe Court  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles W. Brooks

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

m.

6. (b) Name of husband or wife

Elizabeth Brooks7. Birth date of  
deceased (mo., day, yr.)March 19 - 18748. (c) If alive, give age 71 years

8. AGE:

Years

Months

Days

If less than one day

72221

hrs.

min.

9. Birthplace

Annapolis  
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

MOTHER FATHER

12. Name

Thomas Brooks

13. Birthplace

Annapolis

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Elizabeth Brooks

Address

24 Monroe Court

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

June 13/46  
(month) (day) (year)

Cemetery or crematory

Cedar Cliff

Location

Annapolis Md

18. Funeral director

B. L. Hopkins

Address

Annapolis Md

19.

(Date rec'd by registrar)

19. 46

Registra

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 19 46 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19 46 to June 10 19 46  
and that I last saw him 14 alive on June 10 19 46

Immediate cause of death

Coronary Thrombosis

DURATION

Due to

Interventricular

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Annapolis Md Date signed 6/10/46

RECEIVED  
JUN 13 1946  
BUREAU U.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05609

Reg. Dist. No.

10528

1. PLACE OF DEATH:  
County Anne Arundel County  
City or town Crownsville, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 8 years, 8 days  
Hospital, institution, or street address where death occurred:  
Crownsville State Hospital  
How long in hospital or institution? 8 years, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Charles  
City or town Waldorf  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. unknown  
(If rural, give LOCATION)  
2. (a) If veteran, name war unknown

3. (a) FULL NAME BROWN - JAMES RAYMOND  
3. (b) Social Security Number

4. Sex male 5. Color or race black 6. (a) Single, married, widowed, or divorced single  
6. (b) Name of husband or wife  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) 1910  
8. AGE: Years 36 Months unknown Days unknown If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)  
10. Usual occupation Farmer  
11. Industry or business  
12. Name William Brown  
13. Birthplace Maryland  
14. Maiden name Estelle ?  
15. Birthplace unknown

16. Informant Hospital Records  
Address Crownsville, Maryland  
17. Buried Date thereof June 20, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Zion Wesley  
Location Waldorf, Maryland  
18. Funeral director Hunt & Ryan  
Address Waldorf, Maryland  
19. 6-18 46 mp  
(Date rec'd by registrar) (month) (day) (year) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 19 46 at 8:30 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 19 38 to June 18 19 46  
and that I last saw him alive on June 18 19 46

Immediate cause of death Lung Tuberculosis  
DURATION Known to us since 5/4/44

Due to  
Due to  
Other conditions Schizophrenia Known to us since 6/10/38  
(Include pregnancy within 3 months of death)

Major findings of operations  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Manner of injury Injured at work?

23. SIGNATURE [Signature] M. D. or other  
Address Crownsville, Maryland Date signed 6/18/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

E. F. Joyce  
Missouri  
Mo

RECEIVED

JUN 22 1946

BUREAU V.S.



## MARYLAND STATE DEPARTMENT OF HEALTH.

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

05610

28

## 1. PLACE OF DEATH:

County... Anne Arundel County  
 City or town... Crownsville, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year, 16 days  
 Hospital, institution, or street address where death occurred:  
 Crownsville State Hospital  
 How long in hospital or institution? 1 year, 16 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Baltimore  
 City or town... Dundalk  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 117 Chestnut  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... ✓

## 3. (a) FULL NAME

BROWN - LEMON

## 3. (b) Social Security Number

-----

4. Sex Male 5. Color or race black 6.(a) Single, married, widowed, or divorced single (?)  
 6.(b) Name of husband or wife Ada Brown (?)  
 6.(c) If alive, give age ----- years  
 7. Birth date of deceased (mo., day, yr.) 1899 ?  
 8. AGE: Years 47 ? Months unknown Days ----- If less than one day ----- hrs. ----- min.

9. Birthplace Virginia (Town, county, and state)  
 10. Usual occupation Preacher ?  
 11. Industry or business -----  
 12. Name Henry Brown  
 13. Birthplace Virginia  
 14. Maiden name Unknown  
 15. Birthplace Virginia

16. Informant Hospital Records  
 Address Crownsville, Maryland  
 17. Burial Date thereof 6/28/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Hospital  
 Location Crownsville Md  
 18. Funeral director O'Rourke  
 Address  
 19. June 28 19 46 E. Joyce Rose  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH June 25, 1946, at 11:25 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9, 1945, to June 25, 1946, and that I last saw him alive on June 25, 1946.  
 Immediate cause of death General Paralysis of the insane  
 DURATION Known to us since 6/18/45  
 Due to -----  
 Due to -----  
 Other conditions -----  
 (Include pregnancy within 3 months of death)

Major findings of operations ----- Date of op. -----

Autopsy results -----  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ----- Date of -----  
 Where did injury occur? -----  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----  
 Means of injury ----- Injured at work? -----

23. SIGNATURE [Signature]  
 M. D. or other  
 Address Crownsville, Maryland Date signed 6/25/46

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 1 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 05611 28

## 1. PLACE OF DEATH:

County..... Anne Arundel County  
 City or town..... Crownsville, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 8 yrs., 7 mos., 24 days  
 Hospital, institution, or street address where death occurred:  
 Crownsville State Hospital  
 How long in hospital or institution?..... 8 yrs., 7 mos., 24 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Prince George's  
 City or town..... Croome  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... unknown  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

BUTLER - EVELYN

## 3. (b) Social Security Number

4. Sex..... female 5. Color or race..... black 6. (a) Single, married, widowed, or divorced..... single  
 6. (b) Name of husband or wife.....  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... 1917  
 8. AGE: Years..... 29 Months..... unknown Days..... If less than one day..... hrs. .... min.

9. Birthplace..... Maryland  
 (Town, county, and state)  
 10. Usual occupation..... none  
 11. Industry or business.....

FATHER 12. Name..... unknown  
 13. Birthplace..... unknown  
 MOTHER 14. Maiden name..... Fannie (Butler?)  
 15. Birthplace..... unknown

16. Informant..... Hospital Records  
 Address..... Crownsville, Maryland

17. Burial..... Date thereof..... 6/28-46  
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory..... Hospital  
 Location..... Crownsville Md

18. Funeral director..... Suppl. Hosp.  
 Address..... Crownsville Md

19. Date rec'd by registrar..... June 28 1946 27 Joryu Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 23 1946 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 29 1937 to June 23 1946 and that I last saw him alive on June 23 1946

Immediate cause of death..... Lung Tuberculosis  
 Due to.....  
 Due to.....

Other conditions..... Schizophrenia - Catatonic Type  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?.....

23. SIGNATURE..... M. D. or other.....  
 Address..... Crownsville, Maryland Date signed..... 6/23/46

DURATION  
 Known to us since 5/15/45  
 Known to us since 10/29/37

RECEIVED

JUL 1 1946

BUREAU V C

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MD*

## CERTIFICATE OF DEATH

05612 *P*

Reg. Dist. No. *28*

1. PLACE OF DEATH:  
County Anne Arundel County  
City or town Crownsville, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 21 yrs, 3 mos, 6 days  
Hospital, institution, or street address where death occurred:  
Crownsville State Hospital  
How long in hospital or institution? 21 yrs, 3 mos, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
Maryland  
State Maryland County Baltimore  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1706 Mosher Street  
(If rural, give LOCATION) ✓  
2.(a) If veteran, name War -----

3. (a) FULL NAME BUTLER - JOSEPHINE 3. (b) Social Security Number -----

4. Sex female 5. Color or race black B.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife unknown  
6.(c) If alive, give age unk. years  
7. Birth date of deceased (mo., day, yr.) 1862  
8. AGE: Years 84 Months unknown Days unknown If less than one day ----- hrs. ----- min.

9. Birthplace Maryland  
(Town, county, and state)  
10. Usual occupation Laundress  
11. Industry or business -----  
12. Name unknown  
13. Birthplace unknown  
14. Maiden name unknown  
15. Birthplace unknown

16. Informant Hospital Records  
Address Crownsville, Maryland

17. Date thereof 6-3-46  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery or crematory St. Peter's  
Location Balto. Md.  
18. Funeral director Yes. H. Kellogg  
Address 1303 Pressman St  
19. 6/3 19. 86 A. W. Hedrick  
(Date rec'd by registrar) Registrar DM

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 19 46 at 6:00 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 25 19 25 to June 1 19 46  
and that I last saw him/her alive on June 1 19 46

Immediate cause of death Chronic Myocarditis  
DURATION Since 1939

Due to -----  
Due to -----  
Other conditions Senile Psychosis Known to us since 2/25/25  
(Include pregnancy within 3 months of death)

Major findings of operations ----- Date of op. -----

Autopsy results -----  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide ----- Date of -----  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) -----  
Means of injury ----- Injured at work? -----

23. SIGNATURE [Signature] M. D. or other -----  
Address Crownsville, Maryland Date signed 6/1/46

MARGIN RESERVED FOR BINDING

VS-A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

## CERTIFICATE OF DEATH

05613

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Parole Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mary Elizabeth Butler

4. Sex

female

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife

William Butler

7. Birth date of

deceased (mo., day, yr.)

Sept. 16, 1875

6. (c) If alive, give age ..... years

8. AGE:

Years

Months

Days

It less than one day

709

..... hrs. .... min.

9. Birthplace

A. A. Co

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

MOTHER FATHER

12. Name

Henry Butler

13. Birthplace

Md.

14. Maiden name

Matilda Butler

15. Birthplace

Md.

16. Informant

Blanche Johns

Address

Parole Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

June 20, 1946  
(month) (day) (year)

Cemetery or crematory

2nd St.

Location

Parole, Md.

18. Funeral director

W. B. Johnson

Address

Parole, Md.

19.

(Date rec'd by registrar)

June 19, 1946

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new born infants give residence of mother)

State

Md

County

A. A.

City or town

Parole  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 16

19

46, at 8:01 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him

alive on

June 16

19

46

Immediate cause of death

Heart Failure

Due to

Myocardial

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. L. Richardson

M. D. or other

Address

Parole, Md.

Date signed

6/18/46



RECEIVED

JUN 20 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05614

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County a  
 City or town Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital  
 How long in hospital or institution: 19 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County a  
 City or town Davidsonville  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Charles B. Barr

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

m w married

6. (b) Name of husband or wife Amie R. Barr6. (c) If alive, give age 60 years7. Birth date of deceased (mo., day, yr.) June 12 - 1870

8. AGE: Years 76 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Franklin Barr13. Birthplace Maryland14. Maiden name Barbara Ward15. Birthplace Maryland16. Informant Amie R. BarrAddress Davidsonville Md.17. Buried Date thereof June 14/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baldwin MemorialLocation Millersville Md.18. Funeral director R. E. ThompsonAddress Annapolis Md.19. June 14 1946  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 12, 1946 at 11:30 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1946 to June 12, 1946and that I last saw him alive on June 12, 1946Immediate cause of death Death resulting fromthe heart

Due to \_\_\_\_\_

Due to Arteriosclerotic Cardis -Vascular disease

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Albert L. Anderson M.D.Address Annapolis, Md. Date signed 6/14/46

01303

RECEIVED BY THE UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED BY THE UNITED STATES DEPARTMENT OF JUSTICE

JUN 15 1946

RECEIVED  
JUN 15 1946  
BUREAU V.S.

ARTESIAN

RAC CONCENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Ba*

## CERTIFICATE OF DEATH

05615

Reg. Dist. No. *21*

## 1. PLACE OF DEATH:

County *Anne Arundel*  
 City or town *Cypress Creek*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *6 months*  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State *Md.* County  
 City or town *Baltimore*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *1346 Glyndon ave.*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

*Mary C. Carroll*

## 3. (b) Social Security Number

*none*

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

*fem. white widowed*6. (b) Name of husband or wife *James Carroll*7. Birth date of deceased (mo., day, yr.) *1866*8. AGE: Years Months Days If less than one day  
*80* hrs. min.9. Birthplace *Baltimore, Md.*  
(Town, county, and state)10. Usual occupation *housewife*

11. Industry or business

12. Name *Phillip Zoeller*  
13. Birthplace *Baltimore, Md.*14. Maiden name *unknown*  
15. Birthplace *Baltimore, Md.*16. Informant *George Adam Saltzmann*Address *P. O. Severna Park, Md.*17. *burial* Date thereof *6-26-46*  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *New Cathedral cem.*Location *Baltimore, Md.*18. Funeral director *J. J. Cowan & Son*Address *901 Hollins st., Balto., Md.*19. *6-24-46* *L. A. Kreis*  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *June 23* 19 *46* *11.45* P. M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from  
*October 19 45* to *June 23 46*  
and that I last saw h. *er* alive on *June 21* 19 *46*Immediate cause of death *Uremia*2. *General anasarca*DURATION  
*2 days*Due to *Chronic interstitial nephritis**2 yrs.*Other conditions *Chronic valvular heart disease. Arteriosclerosis*  
(Include pregnancy within 8 months of death)*indef.*

Major findings of operations.....Date of op. ....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE *L. A. Kreis M. D.*  
Address *Pandora, Md.* Date signed *6-24-*

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

MEDICAL CERTIFICATION

RECEIVED  
JUN 25 1946  
BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05616

Reg. Dist. No. 20

### 1. PLACE OF DEATH:

County Anne Arundel  
City or town Owensville West River  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? fifty seven years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel  
City or town Owensville West River  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Louisa Cheston

### 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

female white single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 4<sup>th</sup> 1889 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: 57 Years Months Days If less than one day  
fifty seven 3 20 hrs. min.

9. Birthplace Owensville West River Maryland  
(Town, county, and state)

10. Usual occupation house keeping

11. Industry or business

12. Name C. Morris Cheston

13. Birthplace West River A. A. Co. Md.

14. Maiden name Sally C. Murray

15. Birthplace Fauquier Co. Virginia

16. Informant Eleanor M. Shepherd

Address Harwood P.O. A. A. Co. Md.

17. Burial Date thereof June 25, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Christ Church Cemetery

Location Owensville West River Md.

18. Funeral director B. G. Humphrey & Son

Address Salisbury Md.

19. (Date rec'd by registrar) 6/24/46 M. Claytor Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 19 46, at 5 35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9 19 46 to June 24 19 46 and that I last saw him alive on June 24 19 46

Immediate cause of death metastatic carcinoma

Due to carcinoma of right breast

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Emily H. Wilson, M.D. M. D. or other

Address Cathion, Md. Date signed 6/25/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK... Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 28 1946  
BUREAU V.S.

RECEIVED  
JUN 28 1946  
BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

## CERTIFICATE OF DEATH

05617



Reg. Diat. No.

28

## 1. PLACE OF DEATH:

County Anne Arundel CountyCity or town Crownsville, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 years, 14 days

Hospital, institution, or street address where death occurred:

Crownsville State HospitalHow long in hospital or institution? 2 years, 14 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Fairmount Heights  
(If outside city or town limits, write RURAL and give nearest town)Street No. 600 60th Street

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

COBB - RUTH BERNICE

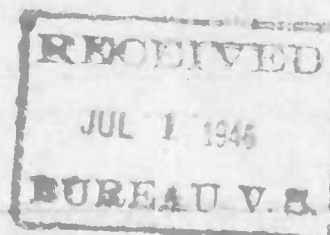
## 3. (b) Social Security Number

unknown4. Sex female5. Color or race black6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife William Cobb, 850 Division Ave., Washington, D. C.7. Birth date of deceased (mo., day, yr.) 18878. AGE: Years 59 Months unknown Days unknown It less than one day unknown hrs. unknown min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Housework11. Industry or business -----12. Name Ledi Prather13. Birthplace Maryland14. Maiden name Martha Simpson15. Birthplace Maryland16. Informant Hospital RecordsAddress Crownsville, Maryland17. Burial Date thereof 6/29/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Brooke GreenLocation Brooke Green Md.18. Funeral director Ray W. BarkerAddress Raytownville Md.19. June 27 19 46 E. F. Joyce Local  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 19 46 at 8:00 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 19 44 to June 26 19 46 and that I last saw her alive on June 26 19 46Immediate cause at death General Arteriosclerosis  
DURATION Known to us since 6/12/44Due to -----Due to -----Other conditions Psychosis with Cerebral Arteriosclerosis  
(Include pregnancy within 3 months of death)Major findings at operations ----- Date of op. -----Autopsy results -----  
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide ----- Date of -----Where did injury occur? -----  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) -----Means of injury ----- Injured at work? -----23. SIGNATURE [Signature] M. D. or other -----  
Address Crownsville, Maryland Date signed 6/26/46





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. ....

## 1. PLACE OF DEATH

County Prince George's  
 City or town Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Prince George'sCity or town Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)Street No. 1218 E. Monument St.  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Shelma Boone Colbert

## 3. (b) Social Security Number

## 4. Sex

female

## 5. Color or race

negro

## 6. (a) Single, married, widowed, or divorced

married  
unknown

## 6. (b) Name of husband or wife

Joseph

## 7. Birth date of deceased (mo., day, yr.)

July 14, 1924  
unknown

## 6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

22

..... hrs. .... min.

## 9. Birthplace

MD  
 (Town, county, and state)

## 10. Usual occupation

unknown - Domestic

## 11. Industry or business

unknown

## FATHER

## 12. Name

William Boone

## 13. Birthplace

MD

## MOTHER

## 14. Maiden name

Marie Bryant

## 15. Birthplace

MD

## 16. Informant

Address

Joseph Colbert  
822 Greenmount Ave.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

6-16-46  
 (month) (day) (year)

Cemetery or crematory

MD Calvary Cem.

Location

C. A. County

## 18. Funeral director

Address

Wm. R. A. Elliott's Daughter  
1129 N. Caroline St.

## 19. Date rec'd by registrar

June 7, 1946Asst. Reg.  
Prack

## MEDICAL CERTIFICATION

20. DATE OF DEATH about June 9, 1946 at ? M21. I CERTIFY that death occurred on the date above stated that I attended deceased from Postmortem Examination and that I last saw him alive on June 15, 1946

Immediate cause of death

Drowning

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

John M. Caffey M.D.

M. D. or other

Address

Annapolis Md.Date signed 6/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05619

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Severn River near Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ced Frederick Road  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Arthur Cole

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

negro

8.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

April, 1918

6.(c) If alive, give age years

8. AGE:

28

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Catonsville, Md.  
(Town, county, and state)

10. Usual occupation

Mechanic

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 23, 1946, at 1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Postmortem Examination  
and that I last saw him alive on June 25, 1946

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6/23/46Where did injury occur? near Darnestown, P.D. Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Severn RiverMeans of injury drowning Injured at work? no

23. SIGNATURE

Address

Date signed 6/25/46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 370

## CERTIFICATE OF DEATH

Reg. Dist. No. 05620 21

### 1. PLACE OF DEATH:

County Anne Arundel  
City or town Annapolis Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Emergency Hospital  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Anne Arundel  
City or town St. Margarets  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Elegabeth Cushing Cowling

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife R. Cleon Cowling  
7. Birth date of deceased (mo., day, yr.) May 22<sup>nd</sup> 1875  
6. (c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 71 Months 18 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Stephensville Md.  
(Town, county, and state)

10. Usual occupation none

11. Industry or business \_\_\_\_\_

12. Name Philip D. Thompson

13. Birthplace Middleburg Va

14. Maiden name Luey C. Gane

15. Birthplace Danville Va.

16. Informant R. Cleon Cowling

Address St. Margarets C.C. Md.

17. Burial Burial Date thereof June 12<sup>th</sup> 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Margarets

Location St. Margarets C.C. Md.

18. Funeral director John M. Taylor Son

Address Annapolis Md.

19. June 12 19 46  
(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1946 at 2 p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1946 to June 9 1946  
and that I last saw her alive on June 9 1946

Immediate cause of death Spotted Fever

### DURATION

1 week

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE George C. Paul M. D. or other \_\_\_\_\_

Address Annapolis Md. Date signed 6-12-46

MARGIN RESERVED FOR BINDING

VS A15 9.45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 14 1946  
BUREAU V.S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT 181-2  
**CERTIFICATE OF DEATH**

Registered No. 23  
5621**1. PLACE OF DEATH:** a.a.g.(a) Baltimore City, Maryland(b) Street address Glensbourne, Md.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.**3 (a) FULL NAME**Ida Watson Davis

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex

Female

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

Henry M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 1, 1877

8. AGE:

69

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Staunton, Va.  
(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

Hugh S. Watson

13. Birthplace

Staunton, Va.

MOTHER

14. Maiden Name

Mattie Stare

15. Birthplace

Staunton, Va.

16 (a) Informant

Mrs. Lily Young

(b) Address

2401 Madison Ave.

17 (a)

Burial  
(Burial, cremation, or removal)

(b) Date thereof

July 3, 1946  
(month) (day) (year)

(c) Cemetery or crematory

Mt. Auburn

Location

Baltimore, Md.

18 (a) Funeral director

Mrs. George W. Holland

(b) Address

1631 Druid Hill Ave.

19 (a)

July 9  
(Date received by registrar)(b) 1946

Registrar

**2. USUAL RESIDENCE OF DECEASED:**

(a) State

Md.

(b) County

(c) City or town

Glensbourne  
(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural, give location)

(e) Citizen of foreign country?

No.

(Yes or No)

If yes, name country

**MEDICAL CERTIFICATION**

20. DATE OF DEATH

July 30, 1946 at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2, 1946 to June 30, 1946, and that I last saw her alive on June 28, 1946.

Immediate cause of death

Acute Nephritis

Duration

Due to

Cardio Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at 11:45 M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Thos. W. M. M. D.

Address

Elkridge Md.

Date signed

July 3, 1946



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 722

## CERTIFICATE OF DEATH

05622

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel  
City or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?  
Hospital, institution, or street address where death occurred:U.S. Naval Hospital  
How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel  
City or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1407 West St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Lt. Commander Stiles M. Decker, Jr. USN

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Madeline L. Decker7. Birth date of deceased (mo., day, yr.) Nov. 28, 1888  
6. (c) If alive, give age years8. AGE: Years 58 Months 6 Days 11 If less than one day hrs. min.9. Birthplace Texas  
(Town, county, and state)10. Usual occupation Lt. Commander, Ret.11. Industry or business U.S. NavyFATHER 12. Name John A. Decker13. Birthplace TexasMOTHER 14. Maiden name unknown15. Birthplace unknown16. Informant Lt. Stiles Decker, Jr.Address 1407 West St Annapolis17. Burial Date thereof June 11, 1946  
(Burial, cremation, or removal, Which? month) (day) (year)Cemetery or crematory St. Anne's CemeteryLocation Annapolis, Md18. Funeral director John W. Taylor & SonAddress Annapolis, Md19. June 10, 1946  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1946 at 1135 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 20, 1945 to June 8, 1946  
and that I last saw him alive on June 8, 1946Immediate cause of death Coronary Heart FailureDue to Valvular Heart Disease 2 yearsAorta Stenosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter J. BerberichAddress U.S. Naval Hospital Annapolis, Md Date signed 6-8-46

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RE  
JUN 11 1946  
BUREAU V.S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MD*

## CERTIFICATE OF DEATH

65623

Reg. Dist. No. 25

### 1. PLACE OF DEATH:

County A.A. Co.  
City or town Brooklyn Pk.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 yrs.  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD. County A.A. Co.  
City or town Brooklyn Pk.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4303 Ritchie Highway  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Mary Demchuk

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Phillip

6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) Dec. 15 - 1893

8. AGE: Years 52 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Poland  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Bever Demchuk

13. Birthplace Poland

14. Maiden name Mary Adakia

15. Birthplace Poland

16. Informant Phillip Demchuk

Address 4303 Ritchie Highway

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 6-8-46  
(month) (day) (year)

Cemetery or crematory Holy Cross

Location A.A. Co.

18. Funeral director Wm. S. Zialkowski

Address 2007 Eastern Ave

19. 6/5 1946 A.W. Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 4 June 46 at 11:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1945, to 4 JUNE 1946  
and that I last saw him alive on 3d JUNE 1946

Immediate cause of death Broncho Pneumonia DURATION 3 days

Due to Hypertensive Cardiovascular renal disease years

Due to

Other conditions Cerebral Stroke April 2, 196

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Lawrence K. Fernan M. D. or other

Address 1938 Linden Ave Date signed 5 June 46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05624

Reg. Dist. No. 21

### 1. PLACE OF DEATH:

County Anne Arundel Co.  
City or town Annapolis Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 19 yrs.  
Hospital, institution, or street address where death occurred:  
17 Lafayette Ave. Annapolis Md.  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Anne Arundel  
City or town Annapolis Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 17 Lafayette Ave.  
(If rural, give LOCATION)  
\*\*\*\*\*  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Mary Agnes Diggs

### 3. (b) Social Security Number

212-24-8487

4. Sex Female 5. Color or race Col. 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 26, 1927 8.(c) If alive, give age 19 years

8. AGE: Years 19 Months 2 Days 0 If less than one day 0 hrs. 0 min.

9. Birthplace Annapolis Md. A. A. Co.  
(Town, county, and state)

10. Usual occupation Government Employee

11. Industry or business None

12. Name James Andrew Diggs

13. Birthplace Annapolis Md.

14. Maiden name Julia Elizabeth Dispriggs

15. Birthplace Annapolis Md.

16. Informant Mrs Julia E. Diggs

Address 17 Lafayette Ave. Annapolis Md.

17. Burial Date thereof 6/8/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Saint Marys Cemetery

Location West St. Extd. Annapolis Md.

18. Funeral director Mrs Charles E. Hicks

Address 45 Northwest St. Annapolis Md.

19. June 7, 1946  
(Date rec'd by registrar)

20. DATE OF DEATH 6-6-46 at 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 46 to June 6th 1946 and that I last saw her alive on June 5th 1946

Immediate cause of death Colitis DURATION 3 or 4 months

Due to IB. Scurvy metastasizing to intestines Mch. 45

Due to to intestines

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. J. Russell MD. M. D. or other Eastport  
Address Eastport Date signed 6-7-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

85001

UNITED STATES DEPARTMENT OF JUSTICE

Central Intelligence Agency

OFFICE OF THE ATTORNEY GENERAL

RECEIVED  
JUN 8 1946  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 485

## CERTIFICATE OF DEATH

Reg. Dist. No.

05625

26

## 1. PLACE OF DEATH:

County Anne Arundel County  
 City or town Crownsville, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 11 months, 10 days  
 Hospital, institution, or street address where death occurred:  
Crownsville State Hospital  
 How long in hospital or institution? 11 months, 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 930 West Lexington Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

EDWARDS - DOROTHY

## 3. (b) Social Security Number

4. Sex female 5. Color or race black 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Theodore Edwards, 930 W. Lexington St., Balto. 6.(c) If alive, give age unk. years  
 7. Birth date of deceased (mo., day, yr.) June 29, 1909  
 8. AGE: Years 36 Months 11 Days 4 (t less than one day) \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business \_\_\_\_\_  
 12. Name Joseph Turner  
 13. Birthplace Maryland  
 14. Maiden name Frances Hall  
 15. Birthplace California

16. Informant Hospital Records  
 Address Crownsville, Maryland  
 17. Burial Date thereof June 8, 1944  
 (Burial, crenation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory St. Auburn  
 Location Elroy O. Wilson  
 18. Funeral director 1000 Beautiful Ave  
 Address 6/7 46 H.W. Reduct  
 19. (Date rec'd by registrar) 6/7 46 H.W. Reduct Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 19 46 at 10:40 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 19 45 to June 5 19 46  
 and that I last saw h. er alive on June 25 19 46  
 Immediate cause of death Carcinoma of Uterus DURATION Known to us since 6/25/45  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Schizophrenia Known to us since 6/25/45  
 (Include pregnancy within 3 months of death)  
 Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accidental, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE [Signature] M. D. or other \_\_\_\_\_  
 Address Crownsville, Maryland Date signed 6/5/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(942)

## CERTIFICATE OF DEATH

05626

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Eastport  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

400 H St Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co.

City or town Eastport  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 400 Fourth Street  
 (If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Walter E. Fisher

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Estelle M. Fisher

## 6. (c) If alive, give age years

## 7. Birth date of

deceased (mo., day, yr.)

Jan. 21<sup>st</sup> 1897

## 8. AGE:

Years

49

Months

5

Days

22

If less than one day

hrs.

min.

## 9. Birthplace

Annapolis, A. A. Co. Md.

(Town, county, and state)

## 10. Usual occupation

Garage Mechanic

## 11. Industry or business

U. S. Naval Academy

## FATHER

## 12. Name

Charles Fisher

## 13. Birthplace

Annapolis, Ind.

## MOTHER

## 14. Maiden name

Lawrence May

## 15. Birthplace

A. A. Co. - Md.

## 16. Informant

Mrs. W. E. Fisher

## Address

400 H St Street - Eastport - Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

June 15<sup>th</sup> 1946

## Cemetery or crematory

Cedar Bluff Cemetery

## Location

Annapolis, Maryland

## 18. Funeral director

John M. Taylor & Son

## Address

Annapolis, Maryland

## 19. June 13 19 46

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 19 46, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 10 19 46, to June 12 19 46and that I last saw him alive on June 12 19 46

Immediate cause of death

Coronary Thrombosis

DURATION

2 days

Due to

Due to

Other conditions

(Include pregnancy within 5 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George C. Boon

M. D. or other

Address

Annapolis MdDate signed 6-12-46

RECEIVED  
JUN 14 1946  
BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20002

## CERTIFICATE OF DEATH

 ★ 0562723  
 Reg. Dist. No.

## 1. PLACE OF DEATH:

 County Anne Arundel  
 City or town Fort George G. Meade  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

regional Hospital

How long in hospital or institution?

about 6 hours

## 3. (a) FULL NAME

PATRICIA M. FORNEY

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

B. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

March 22, 1943

8. AGE:

Years

3

Months

2

Days

24

If less than one day

..... hrs. .... min.

9. Birthplace

Odenton, Md.

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

Herbert J. Forney

13. Birthplace

Patton, Penna.

MOTHER

14. Maiden name

Lillian Marie Stinchcomb

15. Birthplace

Severn, Md.

18. Informant

Herbert J. Forney

Address

Severn, Md.

17.

Burial  
(Burial, cremation, or removal. Which?)

Date thereof

June 18, 1946  
(month) (day) (year)

Cemetery or crematory

Glen Haven

Location

Glen Burnie, Md.

18. Funeral director

Thomas W. Singleton

Address

Glen Burnie, Md.

19.

June 18, 1946  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Severn  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2. (a) If veteran, name war .....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 15, 1946 at 9.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw h..... alive on.....19.....

Immediate cause of death

Undersuressed - feeding

DURATION

Due to

report from medical

Due to

Examiner, regarding

Other conditions

contents of liver - stomach and kidney

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6/15/46Where did injury occur? Severn (City or town) (County) (State)Injured at home, farm, industry, public place (where)? Feed shed

Means of injury

Injured at work?

23. SIGNATURE

W. A. Rayburn, M.D.Address Glen Burnie, Md. Date signed 6/18/46

RECEIVED  
JUN 20 1946  
BUREAU V.S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Bla*

## CERTIFICATE OF DEATH

05628

Reg. Dist. No. *21*

### 1. PLACE OF DEATH:

County *Anne Arundel County*  
City or town *Crownsville, Maryland*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? *10 mos. 25 days*  
Hospital, institution, or street address where death occurred:  
*Crownsville State Hospital*  
How long in hospital or institution? *10 mos. 25 days*

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State *Maryland* County \_\_\_\_\_  
City or town *Baltimore City*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *unknown*  
(If rural, give LOCATION) ✓  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

*GILL - JOHN*

### 3. (b) Social Security Number

4. Sex *Male* 5. Color or race *black* 6.(a) Single, married, widowed, or divorced *Married*

6.(b) Name of husband or wife *Mamie Gill*

7. Birth date of deceased (mo., day, yr.) *1906* 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years *40* Months *unknown* Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace *South Carolina*  
(Town, county, and state)

10. Usual occupation *Laborer*

11. Industry or business \_\_\_\_\_

12. Name *Jim Gill (dead)*

13. Birthplace *South Carolina*

14. Maiden name *Ida Woodluck ? (dead)*

15. Birthplace *South Carolina*

18. Informant *Hospital Records*

Address *Crownsville, Maryland*

17. *Burial* Date thereof *June 28/94*  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location *South Carolina*

18. Funeral director *Elroy C. Wilson*

Address *1000 Brantley Ave*

19. *6-25-94* Registrar

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH *June 24,* 19 *46*, at *9:45 P M*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *August 17,* 19 *45*, to *June 24,* 19 *46*

and that I last saw h. *im alive* on *June 24,* 19 *46*

Immediate cause of death \_\_\_\_\_

*Cerebral hemorrhage*

Due to *hypertens. cardiovascular disease*

Due to *recurrent cerebral hem.*

Other conditions *Psychosis with Cardio-Renal disease*

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ injured at work? \_\_\_\_\_

23. SIGNATURE *W. H. C. Smith*

*Crownsville, Maryland* M. D. or other \_\_\_\_\_

Address \_\_\_\_\_ Date signed *6/24/46*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-0

## CERTIFICATE OF DEATH

Reg. Dist. No. 15629 23

### 1. PLACE OF DEATH:

County Anne Arundel County  
City or town Brooklyn  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Brooklyn  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 311 S Orchard ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3.(a) FULL NAME

Joseph Gorecki

### 3.(b) Social Security Number

4. Sex M 5. Color of face W 6.(a) Single, married, widowed, or divorced Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years 37 Months Days If less than one day hrs. min.

9. Birthplace Olean City N. Y.  
(Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Jacob Gorecki  
13. Birthplace Poland

14. Maiden name Alexandra Bernacki  
15. Birthplace Poland

16. Informant Mrs. Anella Bernacki  
Address 311 S Orchard ave

17. Burial Date thereof 6-26-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sacred Heart of Mary Cem  
Location Baltimore County

18. Funeral director John M. Weber  
Address 401 S. Chester Street

19. 6/25/46 (Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

950

20. DATE OF DEATH June 23 19 46 at P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 46 to June 22 19 46

and that I last saw him alive on June 22 19 46

Immediate cause of death

Chronic Myocarditis and myocardial degeneration

DURATION

8 yrs.

Due to

Chronic Endocarditis (Rheumatic)

10 yrs.

Due to

Other conditions Left Hemiplegia

2 mo.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

P. J. Immaldi M.D.

M. D. or other

Address 4609 Gae. Pickelthorn Date signed 6-25-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 927

## CERTIFICATE OF DEATH

05631  
Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 17 yrs  
 Hospital, institution, or street address where death occurred:  
Manressa-on-Severn  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County A.A.  
 City or town Near Annapolis, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Joseph Henry Gough

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married  
 8. (b) Name of husband or wife Unknown  
 7. Birth date of deceased (mo., day, yr.) March 19, 1875 8. (c) If alive, give age ? years  
 8. AGE: Years 71 Months 2 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Md.  
 (Town, county, and state)  
 10. Usual occupation Care taker  
 11. Industry or business \_\_\_\_\_  
 12. Name Unknown  
 13. Birthplace unknown  
 14. Maiden name Unknown  
 15. Birthplace unknown

18. Informant Rev Fr. Robert S. Lloyd  
 Address Manressa-on-Severn

17. Burial Date thereof June 6, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory New Cathedral  
 Location Baltimore, Maryland

18. Funeral director B.L. Hopping  
 Address 170-172 West St. Annapolis, Md.

19. June 4, 1946  
 (Date rec'd by registrar) Registrar [Signature]

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 3, 1946 at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Postmortem Examination  
 and that I last saw him alive on June 3, 1946

Immediate cause of death

Acute Dilatation of Heart sudden

Due to

Chronic myocarditis unknown

Due to

Arterio-sclerosis unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

John M. Coffey, M.D. Examiner  
 M. D. or other \_\_\_\_\_  
 Address Annapolis Md Date signed 6/3/46

RECEIVED

JUN 5 1946

BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05630

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 yearsHospital, institution or street address where death occurred:  
18 Hill St

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)Street No. 18 Hill St  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Allen F. Browne

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Mary Browne6. (c) If alive, give age 79 years7. Birth date of deceased (mo., day, yr.) Nov 21 - 18908. AGE: Years 75 Months 6 Days 20 If less than one day  
..... hrs. .... min.9. Birthplace Knoxville Tenn  
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name Hartwell Browne13. Birthplace Knoxville Tenn14. Maiden name Unknown15. Birthplace Unknown16. Informant Hartwell BrowneAddress 18 Hill St Annapolis, Md17. Burial Date thereof June 12/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Carson BluffLocation Annapolis Md18. Funeral director B. F. HagginsAddress Annapolis Md19. June 12 1946  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1946 at 830 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1935 to June 10 1946and that I last saw him alive on June 10 1946Immediate cause of death Coronary Thrombosis

DURATION

6-10-46Due to Myocardial infarction 11 yearsDue to Myocardial infarction 11 yearsOther conditions Arteriosclerosis unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C. Bogil M. D. or otherAddress Annapolis Md Date signed 6-11-46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 13 1946

BUREAU V S



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on Film No. 106 - 7/24/46 is especially important. Physicians: please write the causes of death clearly and legibly.

# Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05632 26

Reg. Dist. No.

## 1. PLACE OF DEATH:

County a/a.City or town Luthicum  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

ced Annapolis Rd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County ps.City or town Luthicum - Baeto. 25 -  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Bernadice Hammond -

## 3. (b) Social Security Number

4. Sex Female5. Color or race col.6. (a) Single, married, widowed, or divorced single6. (b) Name of husband or wife -6. (c) If alive, give age - years7. Birth date of deceased (mo., day, yr.) Aug. 19178. AGE: Years 28 Months 29 Days 10 If less than one day - hrs. - min.9. Birthplace a. a. Co.  
(Town, county, and state)10. Usual occupation House Work.

11. Industry or business

12. Name Charles Hammond -13. Birthplace a. a. Co. md.14. Maiden name Mary Hammond15. Birthplace a. a. Co. md.16. Informant Mary HammondAddress Luthicum md17. Burial Date thereof 6/30/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory mt CalvaryLocation Brooklyn Ind18. Funeral director Elroy O. WilsonAddress 1000 Brantly ave19. 6 28 46 Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1946 at 12:10 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1946, to June 27 1946and that I last saw him alive on June 27 1946

Immediate cause of death

Coronary Vascular Disease DURATION 1 day

Due to

Due to

Other conditions Obese 10Congenital dislocation hip Life  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? Date of

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. E. Ball Jr md

M. D. or other

Address Luthicum Date signed 6-27-46



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-6

## CERTIFICATE OF DEATH

05633

Reg. Dist. No. 28

### 1. PLACE OF DEATH:

County Anne Arundel County  
City or town Crownsville, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 year, 2 mos., 27 days  
Hospital, institution, or street address where death occurred:  
Crownsville State Hospital  
How long in hospital or institution? 1 year, 2 mos., 27 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County \_\_\_\_\_  
City or town Baltimore City  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION) \_\_\_\_\_  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

HILL - DENNIS

### 3. (b) Social Security Number

\_\_\_\_\_

4. Sex male 5. Color or race black 6. (a) Single, married, widowed, or divorced unknown

8. (b) Name of husband or wife unknown

7. Birth date of deceased (mo., day, yr.) 1881 ? 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 65? Months unknown Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Unknown  
(Town, county, and state)

10. Usual occupation Unknown

11. Industry or business \_\_\_\_\_

12. Name Unknown

13. Birthplace ??

14. Maiden name Unknown

15. Birthplace ??

18. Informant Hospital Records

Address Crownsville, Maryland

17. burial Date thereof 6/28-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hospital

Location Crownsville

18. Funeral director Suph. Hospital

Address Crownsville Md

19. James H. Joyce 19. 46  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 25, 19 46, at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28, 19 45, to June 25, 19 46, and that I last saw him alive on June 25, 19 46

Immediate cause of death General Paralysis of the insane.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: \_\_\_\_\_

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James H. Joyce M. D. or other \_\_\_\_\_

Address Crownsville, Maryland Date signed 6/25/46

MARGIN RESERVED FOR BINDING

VS-A15

9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5500

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

RECEIVED  
JUL 1 1946  
BUREAU V.B.

*Handwritten signature*

ADJUTANT GENERAL

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 0563421

### 1. PLACE OF DEATH:

County Anne arundel  
City or town Orchard Beach  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 14 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County a. a.  
City or town Orchard Beach  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

John William Hinkle

### 3. (b) Social Security Number

215-07-7525

4. Sex male 5. Color or race white 6. (d) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Catherine Hinkle

7. Birth date of deceased (mo., day, yr.) aug. 28, 1880 6. (c) If alive, give age 62 years

8. AGE: Years 65 Months 9 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Md.  
(Town, county, and state)

10. Usual occupation laborer

11. Industry or business \_\_\_\_\_

12. Name Wm. Hinkle

13. Birthplace Balto., Md.

14. Maiden name Margaret Dayline

15. Birthplace Balto., Md.

16. Informant Catherine Hinkle

Address Orchard Beach

17. Burial Date thereof 6-8-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Cross Cem.

Location a. a. lo.

18. Funeral director Bernard Harla

Address 121 2. West St. Balto.

19. 6-5-46 L. A. O'Neil  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1946 at 10:30 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944 to June 5, 1946

and that I last saw him alive on June 4, 1946

Immediate cause of death Pulmonary & C.

Other conditions Laryngeal and interstitial & C.

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE L. A. O'Neil, M.D.

Address Paradise, Md. M. D. or other \_\_\_\_\_

Date signed 6-5-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 7 1946

BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for date of death is shown on  
FILM No. I O 8 NOV - 8 1946

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 22

## 1. PLACE OF DEATH:

County Anne Arundel  
City or town Annapolis Jct. Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel  
City or town Annapolis Jct. Rural  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

George B Nospros

## 3. (b) Social Security Number

4. Sex

M

5. Color of face

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Oct. 14, 1960

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

85720

hrs.

min.

9. Birthplace

Maryland  
(Town, county, and state)

10. Usual occupation

Retired Painter

11. Industry or business

FATHER

12. Name

Joe Nospros

13. Birthplace

MD

MOTHER

14. Maiden name

unknown

15. Birthplace

MD

16. Informant

Albert E Nospros

Address

Annapolis Jct. MD

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

6-6-46  
(month) (day) (year)

Cemetery or crematory

St Lawrence

Location

Jessup MD

18. Funeral director

DeWitt Donaldson

Address

Lansdowne MD

19. Date rec'd by registrar

June 6

19. 46

Helara Kasson

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 3,1946

at

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

611945

to

631946

and that I last saw him alive on

631945

Immediate cause of death

centralhypertension

DURATION

1 d

Due to

hypertension10 yr

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B Barm

M. D. or other

Address

Harrod

Date signed

6.4.46

RECEIVED

SEP 30 1946

BUREAU V.B.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 45-1

## CERTIFICATE OF DEATH

05635

23

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Anne Arundel Co.

City or town Severn  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? .....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Anne Arundel Co.

City or town Severn  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Minnetonka Road  
(If rural, give LOCATION)

2.(a) If veteran, name war W

### 3. (a) FULL NAME

John E. Hudson

### 3. (b) Social Security Number

none

### 4. Sex

M

### 5. Color or race

W

### 6. (a) Single, married, widowed, or divorced

divorced

### 6. (b) Name of husband or wife

### 7. Birth date of

deceased (mo., day, yr.)

May 14, 1874

### 6. (c) If alive, give age

### 8. AGE:

Years

Months

Days

It less than one day

72

1

15

hr.

min.

### 9. Birthplace

New York  
(Town, county, and state)

### 10. Usual occupation

steelworker

### 11. Industry or business

wire mill

### FATHER

### 12. Name

John E. Hudson

### 13. Birthplace

New York N. Y.

### MOTHER

### 14. Maiden name

Judith Hillinger

### 15. Birthplace

New York

### 16. Informant

### Address

Paul L. Pearson  
Minnetonka Road

### 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

July 2, 1946  
(month) (day) (year)

### Cemetery or crematorium

### Location

Baltimore Cemetery

### 18. Funeral director

### Address

Wm Cook Inc  
1217 St. Paul St.

### 19.

(Date rec'd by registrar)

7-1-46

Arthur D. Hudson

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 19 46, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 19 46 to June 29 19 46.

and that I last saw him alive on 6/29/46 19 46.

### Immediate cause of death

asphyxiation

### DURATION

usual  
for 3 days

### Due to

edema of internal

### Due to

surrounding tissue of throat

### Other conditions

carcinoma of throat

unknown

(Include pregnancy within 8 months of death)

### Major findings of operations

..... Date of op. ....

### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide NO Date of .....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

### 23. SIGNATURE

K. H. Paecher M.D.

M. D. or other

Address

1217 St. Paul St.

Date signed 6/29/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B62)

## CERTIFICATE OF DEATH

05636 21

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County A. A. CO.City or town ANNAPOLIS - MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Five days

Hospital, institution, or street address where death occurred:

Emergency - Hospital.How long in hospital or institution? Five days

## 3. (a) FULL NAME

Valodimir Isachenko

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

8. (b) Name of husband or wife

7. Birth date of unknown 6. (c) If alive, give age about 1916 years

8. AGE:

Years

Months

Days

If less than one day

30

hrs. min.

9. Birthplace Russia - (Moscov)

(Town, county, and State)

10. Usual occupation

11. Industry or business

FATHER

12. Name

unknown

13. Birthplace

MOTHER

14. Maiden name

..

15. Birthplace

..

18. Informant Michel BalabanovAddress Annapolis Emergency Hospital17. CremationDate thereof 6/8/46

Cemetery or crematory

Cedar Hill

Location

Switzerland

18. Funeral director

Joseph Gaudier Sons

Address

Washington, D.C.19. June 8 19 46

Date received by registrar

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 819 46

at

11:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 319 46

to

June 8 19 46and that I last saw h. 17 alive on June 8 19 46

Immediate cause of death

Fractured spinal  
Cord C 6-7-

DURATION

Auto IntoxicationDue to Accidental fall, June 1st, 1946ever

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide AccidentDate of fatal June 1st, 1946

Where did injury occur?

Bay Ridge, Eastport, Md.

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury Accidental fall

Injured at work?

23. SIGNATURE

M. D. or other

Address

Esquivel, recDate signed 6/8/46

RECEIVED

JUN 11 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (167)

## CERTIFICATE OF DEATH

Reg. Dist. No. 05637 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Joyce Md  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

4. Sex male5. Color or race Colored6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 7, 1909

6. (c) If alive, give age..... years

8. AGE: Years 37 Months 3 Days 18 If less than one day

..... hrs. .... min.

9. Birthplace Joyce A.A.Co. Md.  
(Town, county, and state)10. Usual occupation Laborer

## 11. Industry or business

12. Name Charles Jackson13. Birthplace A.A. Co14. Maiden name Alberta Johnson15. Birthplace A.A. Co.16. Informant Alberta JacksonAddress Joyce, Md.17. (Burial, cremation, or removal. Which?) Burial Date thereof June 28, 1946  
(month) (day) (year)Cemetery or crematory Carpenter's HillLocation Joyce Md18. Funeral director W.B. JohnsonAddress Annapolis Md19. June 27, 1946  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1946, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Immediate cause of death Postmortem Examination  
and that I last saw him alive on June 25, 1946Due to Stab wound in Heart

Due to

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 6/25/46Where did injury occur? Arnold, P.A. Maryland  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) at Jones StationMeans of injury sharp instrument Injured at work? NO23. SIGNATURE John M. Claffy M.D. Deputy Medical ExaminerAddress Annapolis Md Date signed 6/27/46

RECEIVED  
JUN 28 1946  
BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05638

Reg. Dist. No. 11

### 1. PLACE OF DEATH:

County Anne Arundel

City or town Eastport  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

821 Bay Ridge Ave.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co.

City or town Eastport  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 821 Bay Ridge Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

John Henry Jacobs

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mary Elizabeth Jacobs

7. Birth date of deceased (mo., day, yr.) June 5<sup>th</sup> 1870

8. AGE: Years 75 Months 11 Days 30 If less than one day  
hrs. min.

9. Birthplace Annapolis - A. A. Co. - Md.  
(Town, county, and state)

10. Usual occupation Policeman (ret.)

11. Industry or business

FATHER 12. Name John Jacobs  
13. Birthplace Annapolis, Md.

MOTHER 14. Maiden name unknown  
15. Birthplace unknown

16. Informant Mrs. J. H. Jacobs  
Address Eastport, Maryland

17. Burial Date thereof June 7<sup>th</sup> '46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Bluff Cemetery

Location Annapolis - Md.

18. Funeral director John M. Taylor & Son  
Address Annapolis, Md.

19. June 6 19 46  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 19 46, at 3 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31 19 46 to June 4 19 46 and that I last saw him alive on June 4 19 46

Immediate cause of death Coronary Thrombosis

DURATION

2 hrs.

Due to Arteriosclerosis

Due to unknown

Due to unknown

Other conditions Coronary Prosthesis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C. Basil  
M. D. or other

Address Annapolis, Md. Date signed 6. 4. 46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 7 1946

BUREAU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

05639

## 1. PLACE OF DEATH:

County..... Anne Arundel  
 City or town..... Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
15 yrs.  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Drown in College Creek while swimming  
 How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Anne Arundel  
 City or town..... Annapolis Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. .... 914 Spa Rd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

## 3.(a) FULL NAME

Samuel Johnson Jr.

## 3.(b) Social Security Number

4. Sex..... Male 5. Color or race..... Col. 6.(a) Single, married, widowed, or divorced..... single  
 B.(b) Name of husband or wife.....  
 6.(c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.)..... February 15, 1931  
 8. AGE: Years..... 15 Months..... 3 Days.....  
 If less than one day..... hrs. .... min.

9. Birthplace..... Annapolis Md. A. A. Co.  
 (Town, county, and state)  
 10. Usual occupation..... School Student  
 11. Industry or business..... None  
 12. Name..... Samuel Johnson Sr.  
 13. Birthplace..... Annapolis Md.  
 14. Maiden name..... Janet Virginia Brown  
 15. Birthplace..... South River Md.

16. Informant..... Mr Samuel Johnson Sr.  
 Address..... 914 Spa. Road Annapolis Md.

17. Burial..... Date thereof..... 6/16/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Asbury Cemetery Smithville  
 Location..... Spa Rd. and Smithville Rd. extd.

18. Funeral director..... Mrs Charles E. Hicks  
 Address..... 45 Northwest St. Annapolis Md.

19. June 16 46  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 13 46 at 5:50 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Post mortem Examination  
June 13 1946

Immediate cause of death.....  
Drowning

Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 8 months of death)

Major findings of operations.....  
 Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Accident Date of..... 6/13/46  
 Where did injury occur?..... Annapolis A. A. Maryland  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)..... College Creek  
 Means of injury..... Drowning Injured at work?..... No

23. SIGNATURE..... John M. Coffey M.D. Deputy Medical Examiner  
 Address..... Annapolis, Md. Date signed..... 6/14/46



RECEIVED  
JUN 19 1946  
BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (464)

## CERTIFICATE OF DEATH

★ 0564021  
Reg. Dist. No. 21

### 1. PLACE OF DEATH:

County Anne Arundel

City or town Rock View Beach  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A.

City or town Rock View Beach  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3.(a) FULL NAME

GERARD H. JORDAN

3.(b) Social Security Number  
none

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife Agnes V. Jordan

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) June 5, 1874

8. AGE: Years Months Days If less than one day  
71 11 29 hrs. min.

9. Birthplace Norfolk, Va.  
(Town, county, and state)

10. Usual occupation boatbuilder

11. Industry or business (retired)

FATHER 12. Name Charles V. Jordan

13. Birthplace Norfolk, Va.

MOTHER 14. Maiden name Josephine Henderson

15. Birthplace Norfolk, Va.

16. Informant Mrs. Agnes V. Jordan

Address P. O. Pasadena, Md.

17. Burial Date thereof 6-6-46  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Louden Park Cem.

Location Baltimore, Md.

18. Funeral director Milton Schilling

Address 3914 S. Hanover st., Balto., Md.

19. 6-3 19 46 L.A. Breit  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 19 46 at 7:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
October 19 45, to June 3 19 46  
and that I last saw him alive on May 12 19 46

Immediate cause of death Carcinoma of the stomach DURATION 2 years

Due to primary

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations inoperable carcinoma of stomach & metastases Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE L.A. Breit, M.D. M.D. or other \_\_\_\_\_

Address Pasadena, Md. Date signed 6-3-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 5 1946  
BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

## CERTIFICATE OF DEATH

Reg. Diet. No. ....

### 1. PLACE OF DEATH:

County B. A.

City or town Linthicum  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 yr.

Hospital, institution, or street address where death occurred:

Old Annapolis Rd.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County aa.

City or town Linthicum  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Old Annapolis Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war.

### 3. (a) FULL NAME

Anna Christina Kaiss.

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Henry Kaiss

7. Birth date of deceased (mo., day, yr.) Jan. 30 - 1869 5.(c) If alive, give age - years

8. AGE: Years 77 Months 4 Days 22 If less than one day - hrs. - min.

9. Birthplace Baltimore Ind.  
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business -

12. Name George Schickelberg

13. Birthplace Germany

14. Maiden name Cassie

15. Birthplace Germany

16. Informant Mr. Fred H. Kaiss.

Address 156 Old Annapolis Road.

17. Burial. Date thereof June - 24/1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory London Park Cemetery

Location Baltimore - Ind.

18. Funeral director Charles J. Schwab.

Address 505 N. Monroe St.

19. June 22 19 46 G. H. Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 19 46, at 12:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 19 46, to June 21 19 46, and that I last saw him alive on June 21 19 46

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to Cardiovascular Disease

Other conditions -

(Include pregnancy within 8 months of death)

Major findings of operations - Date of op. -

Autopsy results - PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of Injury - Injured at work? -

23. SIGNATURE Chas. L. Ball Jr. M.D.

Address Linthicum Date signed 6-21-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 782

## CERTIFICATE OF DEATH

05642

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Emergency Hospital  
 How long in hospital or institution? 54 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn Infants give residence of mother)

State Maryland County Anne Arundel  
 City or town Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 97 Bathurst  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Mary Ellen Kimball

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife John S. Kimball  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) June 27 - 1870  
 8. AGE: Tears 75 Months 11 Days 29 If less than one day..... hrs. .... min.

9. Birthplace Annapolis  
(Town, county, and state)10. Usual occupation Home work

11. Industry or business

12. Name Patrick J. Lamb13. Birthplace Ireland14. Maiden name Bridget Hogan15. Birthplace Ireland16. Informant Catherine KimballAddress 97 Bathurst St Annapolis17. Burial Date thereof June 27/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St Mary'sLocation Annapolis18. Funeral director B. L. HoppingAddress Annapolis19. June 26 46 Registrar J. J. [unclear]  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1946 at 6 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1946 to June 25 1946and that I last saw her alive on June 25 1946Immediate cause of death Myocardial InfarctionDue to arteriosclerosisDue to arteriosclerosis

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE Edna C. Gail M. D. or otherAddress Annapolis Date signed 6-26-46

RECORDED  
JUN 27 1946  
BUREAU V.B.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

## CERTIFICATE OF DEATH

05643

★ Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Green Haven  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

MARGARET M. LANG3. (b) Social Security Number  
none4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Charles Lang7. Birth date of deceased (mo., day, yr.) 1873 6. (c) If alive, give age years8. AGE: Years 73 Months Days If less than one day hrs. min.9. Birthplace Baltimore, Md.  
(Town, county, and state)10. Usual occupation housewife

11. Industry or business

12. Name Emmsbach (?)13. Birthplace Baltimore, Md.14. Maiden name Margaret M. unknown15. Birthplace unknown16. Informant Rudolph T. HewardAddress Green Haven, P.O. Pasadena, Md.17. Burial Date thereof 6-II-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director H. Sanders & SonsAddress North ave. & Broadway, Balto., Md.19. 6-8-46 19 46 L. A. O'Leary  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1600 Bond street  
(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 19 46 at 2.15 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-6 19 46 to 6-8 19 46 and that I last saw h er alive on June 7 19 46Immediate cause of death Auricular fibrillation DURATION ?Chronic Myocarditis; Duration, unknown Cause ?Due to Arteriosclerotic heart diseaseOther conditions Acute cholecystitis 3 days

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?23. SIGNATURE L. A. O'Leary, M.D.Address Pasadena, Md. M.D. or other 6-8-46

Date signed

MARGIN RESERVED FOR BINDING

VS A15-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
JUN 13 1946  
BUREAU V S

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92

## CERTIFICATE OF DEATH

05644

Reg. Dist. No. 20

## 1. PLACE OF DEATH:

County ANNE ARUNDEL  
 City or town WOODLAND BEACH, EDGEWATER, MD.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 yrs 1  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Anne Arundel  
 City or town Edgewater, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

OSCAR LINWOOD LAYTON

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MALE WHITE

6.(b) Name of husband or wife MARY TURPIN LAYTON8.(c) If alive, give age 73 years7. Birth date of deceased (mo., day, yr.) SEPT. 10, 1868

8. AGE: Years 77 Months 8 Days 25 hrs. min.

9. Birthplace BRIDGEVILLE, DEL.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name THOMAS WILLIAMS LAYTON13. Birthplace DELI14. Maiden name MARY WILSON KINDER15. Birthplace DELI16. Informant Mary J. LaytonAddress Edgewater, Md.17. Burial Date thereof June 6, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CemeteryLocation St. Luke's18. Funeral director H. B. WilliamsAddress St. Luke's19. June 4 19 46 Edward C. Williams  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6-4- 19 46 at 10:00 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-25- 19 46 to 6-4- 19 46 and that I last saw him alive on 6-4-46 19 46Immediate cause of death Coronary Occlusion DURATION 1 wk.Due to Myocarditis Chronic 1 yr.Due to Hypertensive Cardio- 6 yrs.  
Vascular diseaseOther conditions Senility 4 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James R. Maitz, M.D.  
185 Prince George St. M. D. or other  
Ann Arbor, Mich. Date signed 6-4-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 12 1946

BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19-2

## CERTIFICATE OF DEATH

05645

Reg. Dist. No.

23

### 1. PLACE OF DEATH:

County ANNE ARUNDEL  
City or town GLEN BURNIE  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, ~~household~~ or institution 310 FIFTH AVE SOUTH-EAST.  
Stay in hospital or inst. (yrs., or mos., or days) NONE  
Stay in this community (yrs., or mos., or days) 71 YRS

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ANNE ARUNDEL  
City or town GLEN BURNIE Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. 310 FIFTH AVE SOUTH - EAST.  
(If rural give LOCATION)  
2(c) IF VETERAN, NAME WAR NONE

### 3. (a) FULL NAME

BENJAMIN FRANKLIN LONG

### 3. (b) Social Security Number

213-05-8311

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife CLARA MORRIS LONG  
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) SEPTEMBER 25, 1874

8. AGE: Years 71 Months 8 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace RURAL - WATERBURY, ANNE ARUNDEL, MARYLAND  
(Town, county, and state)

10. Usual occupation CARPENTER.

11. Industry or business BUILDING

12. Name ROBERT H. LONG.

13. Birthplace ANNE ARUNDEL - WATERBURY

14. Maiden name MADORA WATSON

15. Birthplace ANNE ARUNDEL - WATERBURY

16. Informant MRS. CLARA M. LONG.

Address 310 FIFTH AVE - SOUTH-EAST.

17. Burial Date thereof June 13, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Cedar Hill, Brooklyndale, R.F.D.

18. Funeral director Thomas W. Slaughter

Address Glen Burnie Md.

19. June 12 1946 M. De Alba  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 11 1946, at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 1946, to JUNE 10 1946, and that I last saw him alive on JUNE 10 1946.

Immediate cause of death PULMONARY HEMORRHAGE DURATION 10 mins.

Due to PULMONARY TUBERCULOSIS SEVERAL YEARS.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Henry F. Zangara, M.D. M. D. or other \_\_\_\_\_

Address Glen Burnie, Md. Date signed JUNE 11, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

### PHYSICIAN

Please underline the cause for which death should be charged statistically.

RECEIVED  
JUN 18 1946  
BUREAU 18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9-2

## CERTIFICATE OF DEATH

05646

P

Reg. Dist. No. 21

## 1. PLACE OF DEATH

County Anne Arundel  
 City or town Revera Beach  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 months  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1022 Appleton St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Julia E. Maas

## 3. (b) Social Security Number

4. Sex Female 5. Color of race White 6.(a) Single, married, widowed, or divorced widowed  
 6.(b) Name of husband or wife Joseph Maas  
 7. Birth date of deceased (mo., day, yr.) 1860 6.(c) If alive, give age..... years  
 8. AGE: 86 Years Months Days If less than one day  
 .....hrs. ....min.

9. Birthplace Baltimore City, Md.  
 (Town, county, and state)  
 10. Usual occupation House wife  
 11. Industry or business Home  
 FATHER 12. Name Joseph E. Berli  
 13. Birthplace Germany  
 MOTHER 14. Maiden name unknown  
 15. Birthplace France

18. Informant Louis Edward Maas  
 Address Revera Beach, Md  
 19. Date of death June 18, 1946  
 (Burial, cremation, or removal, Which?)  
 Cemetery or crematory St. Ignace  
 Location Baltimore, Md  
 18. Funeral director Thompson  
 Address 1217 N. East  
 19. Date of death June 18, 1946  
 (Date read by registrar) A. W. Hedrick  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 1946 at 9 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post mortem Examination  
 and that I last saw him June 17, 1946  
 Immediate cause of death Acute dilatation of Heart DURATION  
Chronic Myocarditis  
Chronic Arterial Hypertension  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of Injury Shut in bed Injured at work Depend  
 23. SIGNATURE John M. Caffrey, M.D. Medical Examiner  
 Address Annapolis, Md Date signed 6/19/46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 22

## CERTIFICATE OF DEATH

★ 5647

Reg. Dist. No. 21

### 1. PLACE OF DEATH:

County Anne Arundel

City or town Highland Beach  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? June 22 to June 30, 1946

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County

City or town Washington D.C.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1121 Columbia Rd NW  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

John Walters Matthews

### 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mabel J. Matthews

6. (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) July, 1897 (3)

8. AGE: Years 58 Months Days If less than one day hrs. min.

9. Birthplace Virginia  
(Town, county, and state)

10. Usual occupation Clerk U.S. Govt retired

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Mabel J. Matthews

Address 1121 Columbia Road NW

17. Removal Washington D.C. Date thereof June 30, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington D.C.

Location Robert B. Quinn

18. Funeral director

Address 1826 - 9th St NW

19. June 30 19 46  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 19 46 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22 19 46, to June 30 19 46, and that last saw him alive on June 30 19 46.

Immediate cause of death Cerebral hemorrhage DURATION 2 hours

Due to

Due to

Other conditions Chronic Endocarditis 4 years  
(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

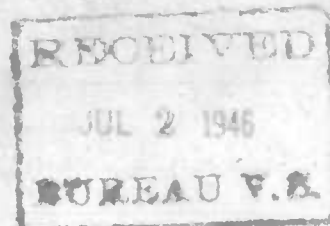
23. SIGNATURE W. A. Wells Jr. M. D. or other  
1161 First St. N.W.  
Address Washington, D.C. Date signed June 30, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





*Concordia*

188

*46 Franklin*

*C. & J. J.  
Davis*

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33a

05648

21

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

Cause: Anna Brundel  
City or town: My Pleasant Beach, Pasadena Co.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? About 2 years  
Hospital, institution, or street address where death occurred: \_\_\_\_\_  
How long in hospital or institution? \_\_\_\_\_

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State: Maryland County: Anne Arundel  
City or town: My Pleasant Beach  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Pasadena P.O.  
(If rural, give LOCATION)  
2.(a) If veteran, name war: \_\_\_\_\_

### 3. (a) FULL NAME

William B. Mc Kinsey (Mc Kinzey)

### 3. (b) Social Security Number

4. Sex: Male 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Widower

6. (b) Name of husband or wife: Catherine M. Mc Kinzey  
(Nee Lowman) 6. (c) If alive, give age: \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.): March 21, 1871

8. AGE: Years: 75 Months: 3 Days: 1 If less than one day: \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace: Prince George's County, Md.  
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: \_\_\_\_\_

12. Name: Don't Know

13. Birthplace: Md.

14. Maiden name: Don't Know

15. Birthplace: Md.

16. Informant: William B. Mc Kinsey (Son)

Address: 203 Hammond's Lane, P.O. Co. 25, Md.

17. Burial Date thereof: June 25, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Anne Arundel County, Md.

18. Funeral director: P. Howard Evans

Address: 1500 P. Charles A., Balto. 30, Md.

19. 6/24/46 19. 46 Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22nd, 1946 at 4:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 12, 1944 to June 22, 1946 and that I last saw him alive on June 22, 1946

Immediate cause of death: Cerebral Hemorrhage DURATION: 2 yrs.

Due to: \_\_\_\_\_

Due to: \_\_\_\_\_

Other conditions: Thrombosis of femoral artery & leg veins 3 weeks  
(Include pregnancy within 8 months of death)

Major findings of operations: \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results: \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: \_\_\_\_\_ Date of: \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

SIGNATURE: Chas. E. Bace Jr. M. D. or other

Address: Linthicum Date signed: 6-22-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05649

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b> County <u>Anne Arundel</u> City or town <u>Chesapeake Bay</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>MARYLAND</u> County City or town <u>BALTIMORE</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>1546 BOYLE ST.</u> (If rural, give LOCATION) 2.(a) If veteran, name war			
<b>3. (a) FULL NAME</b> <u>Margaret E. Metzger</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>Female</u>		<b>5. Color or race</b> <u>white</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>SINGLE</u>		<b>MEDICAL CERTIFICATION</b> <u>about</u>	
<b>6. (b) Name of husband or wife</b>		<b>6. (c) If alive, give age</b> ..... years		<b>20. DATE OF DEATH</b> <u>June 9</u> 19 <u>46</u> , at <u>5P</u> M		<b>21. I CERTIFY</b> that death occurred on the date above stated; that <u>postmortem examination</u> was made on <u>June 15</u> 19 <u>46</u>	
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>DECEMBER 28, 1930</u>		<b>8. AGE:</b> Years <u>15</u> Months <u>5</u> Days <u>24</u> If less than one day ..... hrs. .... min.		<b>Immediate cause of death</b> <u>Drowning</u>		<b>DURATION</b>	
<b>9. Birthplace</b> <u>Baltimore, Md.</u> (Town, county, and state)		<b>10. Usual occupation</b> <u>at home</u>		<b>Due to</b>		<b>Due to</b>	
<b>11. Industry or business</b>		<b>12. Name</b> <u>Charles E. Metzger</u>		<b>Other conditions</b>		(Include pregnancy within 3 months of death)	
<b>13. Birthplace</b> <u>Baltimore Md.</u>		<b>14. Maiden name</b> <u>Catherine Williamson</u>		<b>Major findings of operations</b>		<b>Date of op.</b>	
<b>15. Birthplace</b> <u>Baltimore, Md.</u>		<b>16. Informant</b> <u>James Melton (Step-father)</u>		<b>Autopsy results</b>		<b>PHYSICIAN:</b> Please underline the cause to which death should be charged statistically.	
<b>Address</b> <u>1546 Boyle St, Baltimore, Md</u>		<b>17. Burial</b> <u>Cedar Hill</u> Date thereof <u>June 19, 1946</u> (Burial, cremation, or removal, which?) (month) (day) (year)		<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: <u>Accident</u> <u>6/9/46</u> Accident, suicide, or homicide Date of		<b>Where did injury occur?</b> <u>near Annapolis Beach, A. D.</u> (City or town) (County) (State)	
<b>Cemetery or crematory</b> <u>A. B. Co., Md.</u>		<b>Location</b> <u>A. B. Co., Md.</u>		<b>Injured at home, farm, industry, public place, (where?)</b> <u>Chesapeake Bay</u>		<b>Means of injury</b> <u>Drowning</u> <b>Injured at work?</b> <u>no</u>	
<b>18. Funeral director</b> <u>A. B. Co., Md.</u>		<b>Address</b> <u>4005 S. Charles St. Balto 30</u>		<b>23. SIGNATURE</b> <u>John M. Laffy M.D.</u> <u>Deputy Medical Examiner</u> <u>Annapolis, Md.</u>		<b>Date signed</b> <u>6/15/46</u>	
<b>19. Date rec'd by registrar</b> <u>June 17, 1946</u>		<b>Registrar</b> <u>Alfred W. ...</u>		<b>Address</b>		<b>Date signed</b>	

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 922

## CERTIFICATE OF DEATH

05650

Reg. Dist. No. 21

### 1. PLACE OF DEATH:

County Anne Arundel  
City or town Brimley Park (25)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years  
Hospital, institution, or street address where death occurred:  
23 years

How long in hospital or institution?

### 3. (a) FULL NAME

Annie O. Norfolk

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife William B. Norfolk

7. Birth date of deceased (mo., day, yr.) June 10th, 1870

8. AGE: Years 76 Months 15 Days 15 Less than one day hrs. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John L. W. O'Leary

13. Birthplace Germany

14. Maiden name O'Leary

15. Birthplace Maryland

16. Informant William B. Norfolk

Address 61 - W. 15th Ave. Baltimore, Md.

17. Date thereof June 28, 1946 (month, day, year)

Cemetery or crematory Bedford Park Cemetery

Location Anne Arundel County, Md.

18. Funeral director A. Howard Evans

Address 1400 S. Charles St. Balto. 30, Md.

19. 6-27-46 (Date rec'd by registrar)

Registrar Arthur P. Gifford

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Anne Arundel

City or town Brimley Park (If outside city or town limits, write RURAL and give nearest town)

Street No. 107 - W. 15th Ave. (If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 25th, 1946 at 6:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15, 1946 to June 25, 1946

and that I last saw her alive on June 24, 1946

Immediate cause of death Coronary thrombosis assoc. with aortic regurgitation of heart.

DURATION 15 hours

Due to

Due to

Other conditions General arteriosclerosis; chronic arthritis. ?

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Harry Deibel M.D. or other

Address 1226 Hanover St. Date signed 6/26/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 516

## CERTIFICATE OF DEATH

05651 23  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County Anne Arundel  
City or town Glen Burnie  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 1/2 years  
Hospital, institution, or street address where death occurred:  
none  
How long in hospital or institution? —

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County A. A. Co.  
City or town Glen Burnie  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 104 Oak Lane  
(If rural, give LOCATION)  
2(a) If veteran, name war

### 3. (a) FULL NAME

Richard J. Morris

3. (b) Social Security Number  
none

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Elyah D. Morris  
6. (c) If alive, give age 66 years  
7. Birth date of deceased (mo., day, yr.) Nov 29, 1912  
8. AGE: Years 73 Months 6 Days 54 If less than one day  
.....hrs. ....min.

9. Birthplace St. Mary Co. Md.  
(Town, county, and state)  
10. Usual occupation State Game Warden  
11. Industry or business Son  
12. Name Stevenson Morris  
13. Birthplace St. Mary Co. Md.  
14. Maiden name Mayesek  
15. Birthplace St. Mary Co. Md.  
16. Informant Mr R. J. Morris  
Address Glen Burnie Md.

17. Burial Date thereof 6/6/46  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Holy Cross Cem.  
Location A. A. Co., Md.

18. Funeral director WM. J. TICKNER & SONS  
Address Balto., Md.

19. 6/5 1946 A.W. Hedrick  
(Date Rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 19 46 at 8:20 P M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 45 to June 3 19 46  
and that I last saw him alive on June 3 19 46

Immediate cause of death Carcinoma of the Lung  
Due to Carcinoma of the Prostate  
Due to  
Other conditions  
DURATION  
6 months  
18 months

(Include pregnancy within 3 months of death)  
Major findings of operations Carcinoma of Prostate  
Date of op. Dec. 1945  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE James S. Ballenger M.D.  
M. D. or other  
Address Glen Burnie Md. Date signed June 3 1946

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1450

## CERTIFICATE OF DEATH

05652

Reg. Dist. No. 21

### 1. PLACE OF DEATH:

County Anne Arundel  
City or town Annapolis Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Emergency Hosp. St.

How long in hospital or institution? 13 days

### 3. (a) FULL NAME

William J. O'Meara

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov 5<sup>th</sup> 1942  
B. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 3 Months 6 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Annapolis Md  
(Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name William J. O'Meara

13. Birthplace Geny.

14. Maiden name Jane Martin

15. Birthplace Annapolis Md.

16. Informant Mr. J. Willie Martin

Address Pri St. Annapolis Md

17. Burial Date thereof June 3 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Ann's

Location Annapolis Md.

18. Funeral director John W. Taylor & Son

Address Annapolis Md.

19. June 3 1946  
(Date rec'd by registrar)

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Anne Arundel

City or town Annapolis Md  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Horn Point Eastport  
(If rural, give LOCATION)

2. (a) If veteran, name war

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1946, at 12:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-29- 1946, to 6-2- 1946

and that I last saw him alive on June 2, 1946

Immediate cause of death

Gas gangrene infection DURATION 1 day

Due to Puncture wound generalized 3 days

of foot, left

Due to

Other conditions Anoxemia due

to gas gangrene infection 1 day  
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide accident Date of 5-29-46

Where did injury occur? Annapolis Anne Arundel Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at home

Means of injury stick nail in ft Injured at work? No

Signature James H. Martin, M.D.

185 Prince George St. M. D. or other

Address Annapolis Md. Date signed 6-2-46

MARGIN RESERVED FOR BINDING

VS A15 1 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 4 1946

BUREAU V



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05653

28

Reg. Dist. No.

### 1. PLACE OF DEATH:

County Anne Arundel County  
City or town Crownsville, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 days  
Hospital, institution, or street address where death occurred:  
Crownsville State Hospital  
How long in hospital or institution? 3 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County \_\_\_\_\_  
City or town Baltimore City  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 428 North Eden Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

OVERTON - LILLIAN

### 3. (b) Social Security Number

unknown

4. Sex female 5. Color or race black 6.(a) Single, married, widowed, or divorced single  
6.(b) Name of husband or wife \_\_\_\_\_  
8.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) 8/2/1902  
8. AGE: Years 43 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)  
10. Usual occupation Housework  
11. Industry or business \_\_\_\_\_  
12. Name unknown  
13. Birthplace unknown  
14. Maiden name Cora Sharp  
15. Birthplace Baltimore, Maryland

16. Informant Hospital Records  
Address Crownsville, Maryland

17. Burial Date thereof 6/19/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Chesapeake Memorial Pk.  
Location Baltimore County, Md.  
Charles Harper

18. Funeral director \_\_\_\_\_  
Address 510-512 N. Carrollton Ave

19. June 12 1946 E. J. Joyce Local  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 19 46 at 12:45 A  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 19 46 to June 12 19 46  
and that I last saw her alive on June 12 19 46  
Immediate cause of death Right Hemiplegia stage  
Due to Cerebral Hemorrhage  
Hypertensive Cardio-vascular Disease  
Other conditions Psychosis with Cerebral Arteriosclerosis  
(Include pregnancy within 3 months of death)  
Major findings of operations \_\_\_\_\_  
Date of op. \_\_\_\_\_

Antopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE [Signature] M. D. or other \_\_\_\_\_  
Address Crownsville, Maryland Date signed 6/17/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 14 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 369

## CERTIFICATE OF DEATH

05654

Reg. Dist. No. 28

## 1. PLACE OF DEATH:

County Anne Arundel CountyCity or town Crownsville, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 months, 2 days

Hospital, institution, or street address where death occurred:

Crownsville State HospitalHow long in hospital or institution? 4 months, 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Marlboro  
(If outside city or town limits, write RURAL and give nearest town)Street No. ----- R.F.D. #2  
(If rural, give LOCATION)2.(a) If veteran, name war -----

## 3. (a) FULL NAME

PINKNEY - GEORGIANNA

## 3. (b) Social Security Number

-----4. Sex female 5. Color or race black 6.(a) Single, married, widowed, or divorced single (?)6.(b) Name of husband or wife -----6.(c) If alive, give age ----- years7. Birth date of deceased (mo., day, yr.) 18818. AGE: Years 65 Months unknown Days ----- It less than one day ----- hrs. ----- min.9. Birthplace unknown  
(Town, county, and state)10. Usual occupation Housework11. Industry or business -----12. Name unknown13. Birthplace unknown14. Maiden name unknown15. Birthplace unknown16. Informant Hospital RecordsAddress Crownsville, Maryland17. burial Date thereof 6/11, 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory HospitalLocation Crownsville MdKept.

18. Funeral director

Address Crownsville Md19. 6/11, 46 E. J. Joyce Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 19 46 at 2:16 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 30 19 46 to June 2 19 46and that I last saw h. er alive on June 2 19 46

Immediate cause of death

General Arteriosclerosis

DURATION

Known to us since 1/30/46Due to -----Due to -----Other conditions Senile Psychosis - Syphilis Known to us since 1/30/46

(Include pregnancy within 3 months of death)

Major findings of operations -----Date of op. -----Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----Where did injury occur? ----- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -----Means of injury ----- Injured at work? -----23. SIGNATURE E. J. Joyce M. D. or otherAddress Crownsville, Maryland Date signed 6/2/46

34400

STATE OF TEXAS

DEPARTMENT OF COMMERCE

OFFICE OF THE COMMISSIONER

NOTICE TO THE PUBLIC

RECEIVED  
JUN 13 1946  
BUREAU 7 &

INLAND

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05655

Reg. Dist. No.

### 1. PLACE OF DEATH:

County Anne Arundel  
City or town Mellinville Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution? ✓

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Anne Arundel  
City or town Mellinville Md  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Mary E. H. Ramsey

### 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Frank F. Ramsey

7. Birth date of deceased (mo., day, yr.) about 1866 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 80 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace St. Marys Co., Md  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

FATHER 12. Name Robert H. Wise

13. Birthplace St. Marys Co. Md

MOTHER 14. Maiden name Margaret A. Wise

15. Birthplace St. Marys Co. Md

16. Informant Dr. H. H. H. H.

Address 8 Charlcoate Place

17. Burial Date thereof June 6, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baldwin Mem. Cemy.

Location Severn cross Road A.A. Co.

18. Funeral director John P. Mitchell Sons

Address 1400 Eutaw Place

19. 6-5-46 19 46 Registrar OK Mac

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 19 46 at 9:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3 19 46

and that I last saw him alive on June 3 19 46

Immediate cause of death Cerebral vascular disease - 5 yrs

Due to myocardial degeneration

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE OK Mac M. D. or other \_\_\_\_\_

Address Mellinville Md Date signed 6-4-46

MARGIN RESERVED FOR BINDING

VS A16

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

05656

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town West Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

810 Monterey Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town West Annapolis  
(If outside city or town limits, write RURAL and give nearest town)Street No. 810 Monterey Ave.  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Mary Jane Rehn

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widow

## 6. (b) Name of husband or wife

Herman Rehn

## 7. Birth date of

deceased (mo., day, yr.)

January 15<sup>th</sup> 1868

## 6. (c) If alive, give age

## 8. AGE:

Years

Months

Days

If less than one day

78522

hrs.

min.

## 9. Birthplace

Annapolis - A. A. Co. Md.  
(town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

## FATHER

## 12. Name

Alex Evans

## 13. Birthplace

Annapolis, Md.

## MOTHER

## 14. Maiden name

Sarah Lamb

## 15. Birthplace

Annapolis, Md.

## 16. Informant

## Address

Mr. Alex RehnW. Annapolis, Md.

## 17. Burial

(Burial, cremation, or removal, which?)

## Date thereof

June 9<sup>th</sup> '46  
(month) (day) (year)

## Cemetery or crematory

St. Ann's Cemetery

## Location

Annapolis, Md.

## 18. Funeral director

## Address

John M. Taylor & SonAnnapolis, Md.

## 19.

(Date rec'd by registrar)

June 9 19 46

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

June 6<sup>th</sup> 1946 191946, at 8:45 P. M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 3 1946 to June 5 1946and that I last saw h. ex. alive on June 5 1946

## Immediate cause of death

Cerebral Apoplexy

## Due to

Hemiplegia right side.

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

## Accident, suicide, or homicide

Date of

## Where did injury occur?

(City or town)

(County)

(State)

## Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

John M. Caffy M.D.

M. D. or other

## Address

Annapolis Md

Date signed

6/8/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1000

RECEIVED

CERTIFICATE OF DEATH

RECEIVED  
JUN 11 1946  
BUREAU V.N.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

## CERTIFICATE OF DEATH

05657

Reg. Dist. No. 27

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Fort George G. Meade, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Dropped dead in Theatre #1

Hospital, institution, or street address where death occurred:

Admitted to Regional Hospital, Fort Geo.How long in hospital or institution? G. Meade, Md. dead.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty Anne ArundelCity or town Severn

(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war Soldier, Regular Army 26 yrs.

## 3. (a) FULL NAME

EDWARD C. RENEE

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Mary M. Renee (Wife)1275 Campbellton Rd., Atlanta, Ga. (SW)

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.) July 26, 1896

## 8. AGE:

Years

49

Months

10

Days

25

If less than one day

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 9. Birthplace

Levis, Quebec, Canada

(Town, county, and state)

## 10. Usual occupation

Soldier (T/Sgt.)

## 11. Industry or business

Regular Army

FATHER

## 12. Name

## 13. Birthplace

MOTHER

## 14. Maiden name

## 15. Birthplace

## 16. Informant

Medical and Service RecordsAddress U.S. Army, Ft. Geo. G. Meade, Maryland

## 17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

6/23/46

(month) (day) (year)

Cemetery or crematory

A. M. Patterson & Sons

Location

1020 Spring St. N.W. Atlanta, Ga.

## 18. Funeral director

Address

4914 Belair Road

## 19. 21 June

(Date rec'd by registrar)

19 46

ALLAN C. BROTHMAN, 2nd

Registrar

Lt., MAC.

## MEDICAL CERTIFICATION

/approx.

20. DATE OF DEATH 21 JUNE 19 46 at 0900 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Seen dead only

19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Myocardial insufficiency DURATIONDue to Coronary Occlusion "old"Myocardial Infarct "old"Due to Coronary Sclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations None performed

Date of op. \_\_\_\_\_

Autopsy results Confirmed as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury

Injured at work?

## 23. SIGNATURE

CLASON E. COSNELL Capt MCAddress Regional Hosp. Ft. Meade Md. Date signed 24 June 46

RECEIVED  
JUN 25 1946  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 05658

21

## 1. PLACE OF DEATH:

County ANNE ARUNDELCity or town ANNAPOLIS  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? PRONOUNCED DEAD ON ARRIVAL

Hospital, institution, or street address where death occurred:

EMERGENCY HOSPITAL

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County MarshallCity or town Cameron, W. Va.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 180 Penn. Ave.  
(If rural, give LOCATION)2(a) If veteran, name war World War 11

## 3. (a) FULL NAME

JACKSON L. RUDLE

## 3. (b) Social Security Number

## 4. Sex

MALE

## 5. Color or race

WHITE

## 6. (a) Single, married, widowed, or divorced

SINGLE

## 6. (b) Name of husband or wife

XXXXXXXX

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of deceased (mo., day, yr.)

July 12, 1925

## 8. AGE:

20 Years11 Months3 Days

If less than one day

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 9. Birthplace

Cameron, W. Va.  
(Town, county, and state)

## 10. Usual occupation

Student

## 11. Industry or business

## FATHER

## 12. Name

Refus Ruble

## 13. Birthplace

West Va.

## MOTHER

## 14. Maiden name

Jessie McGranahan

## 15. Birthplace

Shirley, West Va.

## 16. Informant

(Records) Mr. Fish

## Address

Cameron, W. Va.

## 17. Removal

(Burial, cremation, or removal. Which?)

Date thereof June 16, 46  
(month) (day) (year)

## Cemetery or crematory

## Location

Cameron, W. Va.

## 18. Funeral director

Ben L. Hopping

## Address

Annapolis, Md.

## 19. Date rec'd by registrar

June 16, 1946

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

June 15, 1946, at 6:45 P.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

POST MORTEM EXAMINATION  
and that I last saw him alive on June 15, 1946

## Immediate cause of death

## DURATION

HEMORRHAGE

## Due to

LACERATION OF THYROID

## Due to

LACERATION OF LEFT JUGULAR VEIN.

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6/15/46  
Where did injury occur? EDGEWATER, A. A., MARYLAND  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) JUNCTION Hgwy #2+214Means of injury Collision with auto Injured at work? No

## 23. SIGNATURE

John M. Caffrey M.D. deputy medical examiner  
Address Annapolis, Md. Date signed 6/15/46

RECEIVED

JUN 19 1946

BUREAU V S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B2

## CERTIFICATE OF DEATH

05659

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Queen Anne'sCity or town Brooklyn  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Queen Anne'sCity or town Queen Anne's  
(If outside city or town limits, write RURAL and give nearest town)Street No. 100 W. 2nd Ave.  
(If rural, give LOCATION)

2. (a) If veteran, name war

26

## 3. (a) FULL NAME

Bertha Schultz

## 3. (b) Social Security Number

212-10-5756

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age ..... years

## 7. Birth date of deceased (mo., day, yr.)

Nov. 21, 1880

## 8. AGE:

Years

65

Months

6

Days

24

If less than one day

..... hrs. .... min.

## 9. Birthplace

Germany

(Town, county and state)

## 10. Usual occupation

at home

## 11. Industry or business

MOTHER FATHER

12. Name

Michael Schultz

## 13. Birthplace

Germany

## 14. Maiden name

Augusta M. Schuster

## 15. Birthplace

Germany

## 16. Informant

Mrs. Mary Lacher (sister)

## Address

100 W. 2nd St. P.O. Box

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

June 18, 1946

## Cemetery or crematory

Western Cemetery

## Location

Balto., Md.

## 18. Funeral director

## Address

1400 S. Charles St. - Balto. 39, Md.

## 19.

(Date rec'd by registrar)

June 17, 1946W. Hedrich

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 19 46 at 12:27 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15 19 46 to June 15 19 46  
and that I last saw h. alive on June 15 19 46

## Immediate cause of death

coronary atherosclerosis

## Due to

hypertensive cardiac  
vascular disease

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State) .....

Injured at home, farm, industry, public place (where?) .....

## Means of injury

## Injured at work?

## 23. SIGNATURE

P. W. Keister, MD

M. D. or other

Address 302 Patapsco Ave Date signed June 17, 1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

05660

## 1. PLACE OF DEATH:

County Anne Arundel County  
 City or town BALTIMORE EXAM Severna Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 14 YEARS (SUMMER ONLY)  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State M.D. County .....  
 City or town BALTIMORE  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3716 HILLSDALE  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WORLD WAR I ★

## 3. (a) FULL NAME

LOUIS SIEGRIST, JR (Louis Siegrist, Jr.)

## 3. (b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED  
 6.(b) Name of husband or wife MABEL Look Siegrist  
 6.(c) If alive, give age 47 years  
 7. Birth date of deceased (mo., day, yr.) APRIL 21, 1891  
 8. AGE: Years 54 Months 55 Days 1 If less than one day 22 hrs. min.

9. Birthplace BALTIMORE, MD  
 (Town, county, and state)  
 10. Usual occupation Pres.-Treas  
SAFE BUSINESS -  
Calvert Metal Mig. Co.  
 11. Industry or business SAFE

FATHER 12. Name LOUIS SIEGRIST Siegrist  
 13. Birthplace BALTIMORE, MD  
 MOTHER 14. Maiden name MARY Weis  
 15. Birthplace BALTIMORE, MD

16. Informant JOSEPH L. YOUNG  
 Address 4309 SPRINGDALE AVE, BALTO MD

17. Burial Date thereof June 15, 1946  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Druid Ridge Cemetery  
 Location Bethesda, Md.

18. Funeral director Emilio Amoroso  
 Address 4510 Liberty Heights Ave.

19. 6-14 19 46  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1946 at 4:15 PM  
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from POST MORTEM EXAMINATION  
 and that I last saw him alive on June 13, 1946

Immediate cause of death Coronary Embolism DURATION Sudden  
Coronary Polycystic 2 years  
 Due to .....  
 Due to .....  
 Other conditions .....  
 (Include pregnancy within 8 months of death)

Major findings of operations ..... Date of op. ....  
 Autopsy results .....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ..... Date of .....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) .....  
 Means of injury ..... Injured at work? Republ  
Medical  
 Signature John M. Claffy MD Examiner  
Annapolis, Md M. D. or other  
 Address ..... Date signed 6/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 168

## CERTIFICATE OF DEATH

05661

Reg. Dist. No. 24

<b>1. PLACE OF DEATH:</b> County... <u>Anne Arundel Co.</u> City or town... <u>Annapolis Md.</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>31 years</u> Hospital, institution, or street address where death occurred: <u>117 Northwest St.</u> How long in hospital or institution? *****				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Anne Arundel</u> City or town... <u>Annapolis Md.</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>117 Northwest St.</u> (If rural, give LOCATION) ***** 2.(a) If veteran, name war *****			
<b>3. (a) FULL NAME</b> <u>Marian Jennings Simms</u>				<b>3. (b) Social Security Number</b> <u>None</u>			
<b>4. Sex</b> <u>Female</u>		<b>5. Color or race</b> <u>Col.</u>		<b>6.(a) Single, married, widowed, or divorced</b> <u>Married</u>			
<b>6.(b) Name of husband or wife</b> <u>John Henry Simms</u>				<b>6.(c) If alive, give age</b> <u>40</u> years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>July 5, 1915</u>				<b>8. AGE:</b> Years <u>30</u> Months <u>11</u> Days _____ If less than one day _____ hrs. _____ min.			
<b>9. Birthplace</b> <u>Annapolis Md. A. A. Co.</u> (Town, county, and state)							
<b>10. Usual occupation</b> <u>Housewife</u>							
<b>11. Industry or business</b> <u>None</u>							
<b>FATHER</b>		<b>12. Name</b> <u>Fred Jennings</u>					
<b>MOTHER</b>		<b>13. Birthplace</b> <u>A. A. Co. Md.</u>					
<b>14. Maiden name</b> <u>Martha Baily</u>		<b>15. Birthplace</b> <u>Waterbury A. A. Co. Md.</u>					
<b>16. Informant</b> <u>John Henry Simms</u> Address <u>117 Northwest St. Annapolis Md.</u>							
<b>17. Burial</b> (Burial, cremation, or removal. Which?) <u>6/ 5 / 46</u> (month) (day) (year) Cemetery or crematory <u>Brew Hill Cemetery</u> Location <u>West St. Extd. Annapolis Md.</u>							
<b>18. Funeral director</b> <u>Mrs Charles E. Hicks</u> Address <u>45 Northwest St. Annapolis Md.</u>							
<b>19. Date rec'd by registrar</b> <u>June 4 46</u>							
<b>MEDICAL CERTIFICATION</b> <b>20. DATE OF DEATH</b> <u>June 1</u> 19 <u>46</u> at <u>5:12</u> A.M. <b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>Post mortem Examination</u> and that I last saw him <u>alive on June 1</u> 19 <u>46</u> <b>Immediate cause of death</b> <u>Fracture of Skull</u> Due to _____ Due to _____ Other conditions _____ (Include pregnancy within 3 months of death) <b>Major findings of operations</b> _____ Date of op. _____ <b>Autopsy results</b> <b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b> <b>22. VIOLENCE: If death was due to external causes, fill in the following:</b> Accident, suicide, or homicide <u>Homicide</u> Date of <u>5/31/46</u> Where did injury occur? <u>Annapolis</u> <u>P.H. Maryland</u> (City or town) (County) (State) Injured at home, farm, industry, public place (where?) <u>at home</u> Means of injury <u>not known</u> Injured at work? <u>no</u> <b>23. SIGNATURE</b> <u>John M. Coffey M.D.</u> <u>Deputy Medical Examiner</u> Address <u>Annapolis, Md</u> Date signed <u>6/3/46</u>							

Registrar



10030

RECEIVED

JUN 5 1946

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 31

## CERTIFICATE OF DEATH

05662

Reg. Dist. No. 20

1. PLACE OF DEATH: Anne Arundel  
 County Bristol  
 City or town Bristol  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 54 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants, give residence of mother)  
 State Maryland County Anne Arundel  
 City or town Bristol  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2(a) If veteran, name war none

3. (a) FULL NAME Matilda Smith  
 4. Sex Female 5. Color or race col. 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Vernon S. Smith  
 6. (c) If alive, give age 62 years  
 7. Birth date of deceased (mo., day, yr.) June 16 1892

3. (b) Social Security Number  
none

8. AGE: 54 Years 0 Months 0 Days If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Bristol A.C. Co. Md.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Thomas Sellman  
 13. Birthplace Lothian

14. Maiden name Victoria Coates  
 15. Birthplace Bristol

16. Informant Vernon S. Smith  
 Address Bristol A.C. Co. Md.

17. Burial Date thereof June 18, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Walkers Ledge  
 Location Bristol Md.

16. Funeral director F.A. Staudt & Son  
 Address Baltimore Md.

19. 6/18 19 46 Mr. Clayton  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 19 46 at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 12 19 43, to June 16 19 46, and that I last saw him alive on May 27 19 46

Immediate cause of death Myocarditis Chronic  
 Due to \_\_\_\_\_ DURATION 2 yrs.

Other conditions Partial paralysis from Cerebral thrombosis  
 (Include pregnancy within 6 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE F.B. West  
 Address Lothian, Md. Date signed 6/17/46  
 M. D. or other \_\_\_\_\_

54  
66  
7661

RECEIVED  
JUN 19 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

## CERTIFICATE OF DEATH



05663

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel Co.  
 City or town Eastport Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Since June 8, 1946  
 Hospital, institution, or street address where death occurred:  
515 4th Street EastPort Md.  
 How long in hospital or institution? \*\*\*\*\*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Doylestown Pa. County Delaware Co.  
 City or town Doylestown outside Phila. Pa.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 186 Ashland St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None ✓

## 3. (a) FULL NAME

Lillie Anne Stratton

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race Col. 6.(a) Single, married, widowed, or divorced Widow  
 6.(b) Name of husband or wife \*\*\*\*\*  
 6.(c) If alive, give age \*\*\*\*\* years  
 7. Birth date of deceased (mo., day, yr.) April 15, 1865  
 8. AGE: Years 81 Months 2 Days        If less than one day        hrs.        min.

9. Birthplace Philadelphia Delaware Co. Pa.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business None12. Name Alexandria Councillor13. Birthplace Chaney Pa.14. Maiden name Lydia Pierce15. Birthplace Chaney Pa.16. Informant Mrs Myrtle JacksonAddress 515 4th St. EastPort Md.17. Shipped Date thereof 6/ 28/ 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Doylestown CemeteryLocation Doylestown Pa.18. Funeral director Mrs Charles E. HicksAddress 45 Northwest St. Annapolis Md.19. June 28 19 46  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 19 46 at 5:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 19 46 to June 27 19 46 and that I last saw her alive on June 27 19 46Immediate cause of death Carcinoma of Gall-bladder & Liver

DURATION

Due to       Due to       Other conditions       

(Include pregnancy within 3 months of death)

Major findings of operations       Date of op.       Autopsy results       

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide        Date of       Where did injury occur?        (City or town) (County) (State)Injured at home, farm, industry, public place (where?)       Means of injury        Injured at work?       23. SIGNATURE A. St. Allen M.D.Address 17 Carroll St. Date signed 6-27-46

RECEIVED  
JUL 1 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

## CERTIFICATE OF DEATH

Reg. Dist. No. 23

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Odenton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Frank M. Taylor

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Florence Taylor

## 7. Birth date of

deceased (mo., day, yr.)

Oct. 2, 18816. (c) If alive, give age 58 years

## 8. AGE:

Years

Months

Days

If less than one day

64812

hrs.

min.

## 9. Birthplace

Toledo Ohio  
(Town, county, and state)

## 10. Usual occupation

store-keeper

## 11. Industry or business

general merchandise

## FATHER

## 12. Name

Fred Taylor

## 13. Birthplace

England

## MOTHER

## 14. Maiden name

Margaret McKeuzie

## 15. Birthplace

Canada

## 16. Informant

Mrs. Florence Taylor

## Address

Odenton Maryland

## 17. Burial

(Burial, cremation, or removal, Which?)

Date thereof June 17 1946

(month) (day) (year)

## Cemetery or crematory

Holy Cross

## Location

Cedar Hill, Brooklyn Md. R.F.D.

## 18. Funeral director

Thomas W. Singleton

## Address

New Burnie, Md.

## 19. June 17

(Date rec'd by registrar)

1946

Medialba

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Odenton

(If outside city or town limits, write RURAL and give nearest town)

Street No. # Maple Road

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1946 at 2-7 20 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 14 1946 to June 13 1946and that I last saw him alive on June 13 1946

## Immediate cause of death

Coronary embolism

## Due to

Coronary sclerosis

## Due to

## DURATION

4 weeks6 years

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John M. Coffey M.D.Address Baltimore, Md Date signed 6/14/46

RECEIVED  
JUN 20 1946  
BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05665

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County aa  
 City or town Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 24 years  
 Hospital, institution, or street address where death occurred:  
108 West St  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County aa  
 City or town Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 108 West St  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Lucy Taylor

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Bernard R Taylor  
 6. (c) If alive, give age 46 years  
 7. Birth date of deceased (mo., day, yr.) June 15 - 1879  
 8. AGE: Years 67 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Annapolis  
 (town, county, and state)  
 10. Usual occupation House wife  
 11. Industry or business \_\_\_\_\_  
 12. Name Daniel Black  
 13. Birthplace Annapolis, Md.  
 14. Maiden name Bessie F. Logan  
 15. Birthplace Annapolis, Md.

16. Informant Bernard R Taylor  
 Address 108 West St. Annapolis, Md.  
 17. Burial (Burial, cremation, or removal, Which?) Date thereof July 3/46  
 (month) (day) (year)  
 Cemetery or crematory St Mary's  
 Location Annapolis, Md.  
 18. Funeral director B. L. Hopping  
 Address Annapolis, Md.  
 19. July 1 1946  
 (Date received by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1946 at 7 P M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1940 to June 29 1946  
 and that I last saw him alive on June 29 1946  
 Immediate cause of death Myocardial infarction & myocardial infarction  
 Due to arteriosclerosis  
 Due to \_\_\_\_\_  
 Other conditions Chr. nephritis  
 (Include pregnancy within 3 months of death)

## DURATION

5 years  
unlabeled  
5 years

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Lucy Taylor M. D. or other \_\_\_\_\_  
 Address Annapolis, Md. Date signed 7-1-46

RECEIVED

JUL 2 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-5)

05666

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Eastport  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

909 Munroe St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co.City or town Eastport  
(If outside city or town limits, write RURAL and give nearest town)Street No. 909 Munroe St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Georgiana Thomas

## 3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) February 24 18628. AGE: Years 84 Months 4 Days 19 hrs. min.9. Birthplace Annapolis - A. A. Co. - Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name James T. Thomas13. Birthplace Annapolis, Md.14. Maiden name Mary H. Lane15. Birthplace A. A. Co. - Md.16. Informant Mrs. Adam OkruschAddress Eastport - Maryland17. Buried Date thereof June 28th '46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St. Anne's CemeteryLocation Annapolis - Md.18. Funeral director John W. Taylor & SonAddress Annapolis, Md.19. June 24 1946  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1946 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 15 1946 to June 21 1946  
and that I last saw him alive on June 21 1946

Immediate cause of death

Acute Keratinia

DURATION

3 daysDue to Cr. Interstitial NephritisaboutDue to Cr. Arteriosclerosis20-30 yrsOther conditions hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Oliver Purvis

M. D. or other

Address Annapolis Md Date signed 6/21/46

RECEIVED  
JUN 25 1946  
BUREAU V.B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

## CERTIFICATE OF DEATH

05667

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel Co.City or town Annapolis Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 70 years

Hospital, institution, or street address where death occurred:

70 yearsHow long in hospital or institution? \*\*\*\*\*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Annapolis Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 21 Clay St.  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3. (a) FULL NAME

Lizzie Thomas

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FemaleCol.Married6. (b) Name of husband or wife Wardell Thomas7. Birth date of deceased (mo., day, yr.) March 17, 1876

8. AGE: Years Months Days If less than one day

70200 hrs. 0 min.9. Birthplace Annapolis Md. A. A. Co.  
(Town, county, and state)10. Usual occupation Dress maker11. Industry or business None12. Name Joseph Simpson13. Birthplace Annapolis Md.14. Maiden name Annie Coney15. Birthplace A. A. Co. Md.16. Informant Mr Wardell ThomasAddress 21 Clay St. Annapolis Md.17. Burial Date thereof 6/ 12/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetary or crematory Brew Hill CemeteryLocation West St. Extd.18. Funeral director Mrs Chas. E. HicksAddress 45 Northwest St. Annapolis Md.19. June 12 19 46  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1946 at 11:10 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1946 to June 9 1946and that I last saw him alive on June 9 1946Immediate cause of death Acute Cor. VascularfailureDue to ArteriosclerosisOther conditions ArteriosclerosisMajor findings of operations ArteriosclerosisAntopsy results Arteriosclerosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Arteriosclerosis Date of June 9 1946

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. E. Hicks M. D. or otherAddress Annapolis Md Date signed June 11/46

1000

ARTISTIAN LE 0656

PAG CONTENT

RECEIVED

JUN 13 1946

BUREAU T S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

05668

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

90 East Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County P. A. Co.City or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)Street No. 90 East Street  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Charles Winfield Tucker

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Hester S. Tucker

8. (c) If alive, give age ..... years

## 7. Birth date of deceased (mo., day, yr.)

September 15<sup>th</sup> 1861

## 8. AGE:

Years

Months

Days

If less than one day

84911

hrs.

min.

## 9. Birthplace

Annapolis - P. A. Co. - Md.  
(Town, county, and state)

## 10. Usual occupation

Shut Metal Worker

## 11. Industry or business

FATHER

## 12. Name

John Tucker

## 13. Birthplace

Annapolis, Md.

MOTHER

## 14. Maiden name

Lavinia Jones

## 15. Birthplace

Maryland

## 16. Informant

Mrs. Mary Mills

## Address

Annapolis, Md.

## 17.

(Burial, cremation, or removal, Which?)

Date thereof June 29<sup>th</sup> 46  
(month) (day) (year)

## Cemetery or crematory

Cedar Bluff Cemetery

## Location

Annapolis, Md.

## 18. Funeral director

John W. Taylor & Son

## Address

Annapolis, Md.

## 19.

June 28, 1946  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 26, 1946, at 9:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 20, 1946 to June 26, 1946and that I last saw him alive on June 26, 1946

Immediate cause of death

Pulmonary Edema Acute

DURATION

3 days

Due to

Cardiac Failure

2 wks.

Due to

Hypertensive Cardio-vascular Disease

6 years

Other conditions

Hemiplegia, partial left

5 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James R. Martin, M.D.  
M. D. or other

Address

185 Prince George St.  
Annapolis, Md.Date signed 6-27-46



RECEIVED

JUL 1 1946

BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22-2)

## CERTIFICATE OF DEATH

05669

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County... Anne Arundel  
 City or town... Furnace Branch Road - P.O. Brooklyn  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... 30 years  
 Hospital, institution, or street address where death occurred:  
Furnace Branch Rd. - P.O. Brooklyn  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Anne Arundel  
 City or town... P.O. Brooklyn  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... Furnace Branch Road  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war.....

## 3. (a) FULL NAME

Mrs. Frank Joseph Vokroy

## 3. (b) Social Security Number

4. Sex... M. 5. Color or race... W. 6. (a) Single, married, widowed, or divorced... Widowed

6. (b) Name of husband or wife... Mary Lelada Vokroy7. Birth date of deceased (mo., day, yr.)... December - 1867

8. AGE: Years... 78 Months... 7 Days... ? If less than one day... hrs. .... min. ....

9. Birthplace... Europe  
(Town, county, and state)10. Usual occupation... Blacksmith

## 11. Industry or business

12. Name... Frank Vokroy13. Birthplace... Europe14. Maiden name... ?15. Birthplace... ?16. Informant... Frank J. Vokroy (Son)Address... Furnace Branch Rd. - P.O. Brooklyn17. Burial Date thereof... 6-18-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Holy RedeemerLocation... Belt, Md.18. Funeral director... Frank BrachsonAddress... 900 N. Chester St. 519. 6-17 19. 46 unpublished  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... June 14 19. 46 12:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 12 19. 46 to June 14 19. 46and that I last saw him alive on June 13 19. 46Immediate cause of death... Cerebral artery diseaseDue to... senilityDue to... Right cerebral artery

Other conditions... ..

(Include pregnancy within 3 months of death)

Major findings of operations... None

Date of op. ....

Autopsy results... ..

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... No Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE... Estelle H. Paulsen M.D.Address... Belt, Prince Md. M. D. or otherDate signed... 6/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

★ 5670

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Annapolis Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

James Harlin Way

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Lillian Mae Way

7. Birth date of deceased (mo., day, yr.)

Dec 22<sup>nd</sup> 1911

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

34514

hrs.

min.

9. Birthplace

Tennessee  
(Town, county, and state)

10. Usual occupation

(Auto) Mechanist

11. Industry or business

John Way

12. Name

Tenn.

13. Birthplace

Lillian Brown

14. Maiden name

Tenn.

15. Birthplace

Lillian Mae Way

16. Informant

Pasadena. Q. Q. Co. Md.

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Glen Haven

Location

Glen Burnie Md.

18. Funeral director

John M. Taylor. Con

Address

Annapolis Md.

19. Date rec'd by registrar

June 6 1946

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Pasadena  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 5 1946 at 2<sup>10</sup> P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Post mortem Examination

and that I last saw him alive on

June 5 1946

Immediate cause of death

Fracture of skull

Due to

Hernia of Brain

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6/5/46Where did injury occur? near Parole (City or town) A. A. Maryland (County) (State)Injured at home, farm, industry, public place (where?) at Asher's PlaceMeans of injury Truck and Bull-dozen Injured at work? YesJohn M. Raffy M.D. (Signature) Deputy Medical Examiner23. SIGNATURE Annapolis, Md. M. D. or otherAddress Annapolis, Md. Date signed 6/6/46

0712

RECEIVED

RECEIVED  
JUN 7 1946  
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

## CERTIFICATE OF DEATH

05671

Reg. Dist. No. 5.3

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Glen Burnie  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 yrs.  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Anne Arundel  
 City or town Glen Burnie  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 308 D. St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Bertha Weidenhoff

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
 6. (b) Name of husband or wife Late Ludwig  
 7. Birth date of deceased (mo., day, yr.) Sept 12 - 1871 8. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 74 Months 8 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Germany  
 (Town, county, and state)10. Usual occupation Housewife11. Industry or business at home12. Name John Borkmann13. Birthplace Germany14. Maiden name Unknown15. Birthplace Germany16. Informant Mr. Stated NetteAddress 308 D. St. Glen Burnie Md.17. Buried Date thereof June 7 - 46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory 1st United Ev. Luth. Ch.Location Baltimore Md.18. Funeral director Thomas W. SingletonAddress Glen Burnie Md.19. June 6 19 46 MDA15  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 19 46 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_

Probable cause of death arteriosclerosisDue to circulatory diseaseDue to arteriosclerosis

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Ernest H. PaubertAddress Glen Burnie Md. Date signed 6/4/46

RECEIVED  
JUN 8 1946  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Chesapeake Bay  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County .....City or town Baltimore, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1510 Boyle St.  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Dorothy E. White

## 3. (b) Social Security Number

217-18-6624

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

7. Birth date of  
deceased (mo., day, yr.)November 21, 1923.

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

22618

..... hrs. .... min.

9. Birthplace.....

Baltimore, Md.  
(Town, county, and state)

10. Usual occupation.....

Packing Dept

11. Industry or business.....

Mc. Cormick & Co.

MOTHER

FATHER

12. Name.....

Carroll W. White

13. Birthplace.....

Baltimore, Md.

14. Maiden name.....

Mary E. Anderson

15. Birthplace.....

Baltimore, Md.

16. Informant.....

Carroll W. White (father)

Address

1510 Boyle St. Baltimore, Md17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

June 17, 1946  
(month) (day) (year)

Cemetery or crematory.....

Cedar Hill

Location.....

P. P. Co., Inc.

18. Funeral director.....

B. Howard Evans

Address

1400 S. Charles St. Balto. 39, Md19. June 17

Date rec'd by registrar

19. 46Ann H. Smith  
Registar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 9 19 46 at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Postmortem Examination  
and that I last saw him June 15 19 46 alive on

Immediate cause of death.....

Drowning

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident Date of 6/9/46  
Accident, suicide, or homicideWhere did injury occur Near Pasadena Park, P. P., Maryland  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Chesapeake BayMeans of injury Drowning Injured at work? NoSignature John M. Claffy, M.D. Deputy  
M. D. or other Medical ExaminerAddress Baltimore, Md. Date signed 6/15/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05673

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1301 West  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Joseph Daniel White

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Helen Hantake White

## 7. Birth date of

deceased (mo., day, yr.)

1915

## 6. (c) If alive, give age

## 8. AGE:

Years

Months

Days

If less than one day

31

hrs.

min.

## 9. Birthplace

Annapolis Md.  
(Town, county, and state)

## 10. Usual occupation

St. N. S. A. C.

## 11. Industry or business

Joseph Daniel White

## 12. Name

## 13. Birthplace

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17. Burial

## (Burial, cremation, or removal. Which?)

## Date thereof

## (month) (day) (year)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19. Date rec'd by registrar

## Registrar

## Address

## Date signed

## 6/10/46

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

June 7, 1946 at 7:20 M

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Postmortem Examinationand that I last saw him alive on June 7, 1946

Immediate cause of death

Coronary occlusion

Due to

Coronary sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Signature

Address

Date signed

6/10/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 11 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05674

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? two days  
 Hospital, institution, or street address where death occurred:  
Emergency Hospital  
 How long in hospital or institution? two days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Washington  
 City or town D.C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6141 Sligo Mill Rd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war World War II ☒

## 3.(a) FULL NAME

Dale W. Williams

## 3.(b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced M  
 6.(b) Name of husband or wife Julia Williams  
 6.(c) If alive, give age 37 years  
 7. Birth date of deceased (mo., day, yr.) July 22, 1912  
 8. AGE: Years 33 Months 11 Days 3 If less than one day  
hrs. min.

9. Birthplace W. Va.  
 (Town, county, and state)  
 10. Usual occupation Auto mechanic  
 11. Industry or business

12. Name unknown  
 13. Birthplace unknown  
 14. Maiden name unknown  
 15. Birthplace unknown

16. Informant Julia Williams  
 Address 6141 Sligo Mill Road, Washington  
 Removal 6/25/46 Date thereof (month) (day) (year)

Cemetery or crematory Washington D.C.  
 Location Arthur Waters

18. Funeral director 254 Carroll St. Washington D.C.  
 Address

19. June 25 19 46  
 (Date rec'd by registrar) Registrar J. J. Smith

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 25, 1946 at 3:21 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 23, 1946 to June 25, 1946  
 and that I last saw him alive on June 25, 1946 19

Immediate cause of death Respiratory Failure

Due to Pulmonary edema

Due to Aspiration of water

Other conditions Trans section of cervical spinal cord; Fr. of cervical spine  
 (Include pregnancy within 8 months of death)

Major findings of operations Trans section of cervical spinal cord; Fr. of cervical spine

Autopsy results Trans section of cervical spinal cord; Fr. of cervical spine  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of June 23, 1946

Where did injury occur? Riv. A.A. Md.  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public place

Means of injury Diving in shallow water Injured at work?

23. SIGNATURE Edward F. Ritchie M. D. or other

Address 184 Gloucester St. Annapolis, Md. Date signed June 26, 1946

RECEIVED

JUL 1 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Rock Creek Pasadena P.O.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? not known

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Daniel Wisniewski

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Kitty Wisniewski

## 7. Birth date of deceased (mo., day, yr.)

July 6 1917

## 8. (c) If alive, give age..... years

## 8. AGE:

29

Years

Months

Days

If less than one day

.....hrs. ....min.

## 9. Birthplace

Baltimore  
(Town, county, and state)

## 10. Usual occupation

Stevenson

## 11. Industry or business

FATHER

## 12. Name

Walter Wisniewski

## 13. Birthplace

Poland

MOTHER

## 14. Maiden name

Fay Bronget

## 15. Birthplace

Poland

## 16. Informant

Walter Wisniewski

## Address

601 8. Montford Ave

## 17. Burial

(Burial, cremation, or removal, which?)

Date thereof June 28-46  
(month) (day) (year)

## Cemetery or crematory

Holy Rosary

## Location

Baltimore Co.

## 18. Funeral director

Wm. J. Fialkowski

## Address

2007 Eastern Ave

## 19. 6-18

(Date rec'd by registrar)

19.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland, County.....City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 601 So. Montford

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 17 1946 at 540 P.M.

21. I CERTIFY that death occurred on the date above stated; was attended by.....

POST MORTEM EXAMINATION  
and autopsy was performed on..... 19.....

Immediate cause of death.....

DURATION

Due to.....

Due to.....

Other conditions.....

Drowning  
accident

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6/17/46Where did injury occur near  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Rock CreekMeans of injury drowning Injured at work? yes

23. SIGNATURE

John M. Cletty M.D. medical examinerAddress Annapolis, Md. Date signed 6/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05676

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel Co.City or town Annapolis Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 31 years

Hospital, institution, or street address where death occurred:

12 College Creek TerraceHow long in hospital or institution? \*\*\*\*\*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel Co.City or town Annapolis Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 12 College Creek Terrace  
(If rural, give LOCATION)2.(a) If veteran, name war \*\*\*\*\*

## 3. (a) FULL NAME

Alverta Amelia Woody

## 3. (b) Social Security Number

212-14-1908

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Col. Married

6. (b) Name of husband or wife Daniel Alque Woody6. (c) If alive, give age 32 years7. Birth date of deceased (mo., day, yr.) March 19, 19158. AGE: Years Months Days If less than one day  
31 2 ..... hrs. .... min.9. Birthplace Annapolis Md. A. A. Co.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business None12. Name Edward Louis Parker13. Birthplace Annapolis Md.14. Maiden name Carrie McGowans15. Birthplace Annapolis Md.16. Informant Mr. Daniel WoodyAddress 12 College Creek Terrace Annapolis Md.17. Burial Date thereof June 6, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Brew Hill CemeteryLocation West St. Extd. Annapolis Md.18. Funeral director Mrs. Charles E. HicksAddress 45 Northwest St. Annapolis Md.19. June 6, 1946  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1946 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on June 2, 1946Immediate cause of death Primary Carcinoma of Vagina DURATION 2 years

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE R. L. Richardson M. D. or otherAddress Blues fork ind Date signed 6/7/46



RECEIVED

JUN 7 1946

BUREAU VS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**MARYLAND STATE DEPARTMENT OF HEALTH**

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. ....1.....

115672

1. PLACE OF DEATH: Annrs Annapolis  
County near Annapolis in Severn River  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Melrose Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME Henry C. Wuntzer 3. (b) Social Security Number 213-03-2108

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Elizabeth Wuntzer 6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) Sept. 24, 1910  
8. AGE: Years 35 Months 8 Days 29 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
9. Birthplace Orange Grove, Balto. Co., Md.  
(Town, county, and state)  
10. Usual occupation Engineer  
11. Industry or business Ship Yards

12. Name Charles C. Wuntzer  
13. Birthplace Baltimore Co., Md.  
14. Maiden name Mary M. Coster  
15. Birthplace Perry Hall, Md.

16. Informant Mrs. Mary M. Wuntzer  
Address Melvin Ave. & Old Ford Rd.  
17. Burial Date thereof June 27, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory New Catholic Cem.  
Location Baltimore, Md.  
18. Funeral director Easton Sons  
Address Ellicott City, Md.  
6/27 & 8/1/46  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION about  
20. DATE OF DEATH June 23, 1946 at 1 A.M.  
21. I CERTIFY that death occurred on the date above stated: Not attempted deceased from  
Post-mortem Examination  
and that I list Saw Shro on June 26, 1946  
Immediate cause of death Drowning  
DURATION  
Due to  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)  
Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Accident Date of 6/23/46  
Where did injury occur near Annapolis, A.P., Md.  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) Severn River  
Means of injury drowning Injured at work? No  
John M. Coffey, M.D. Deputy  
23. SIGNATURE Annapolis, Md. M. D. or other Physician  
Address Annapolis, Md. Date signed 6/26/46